







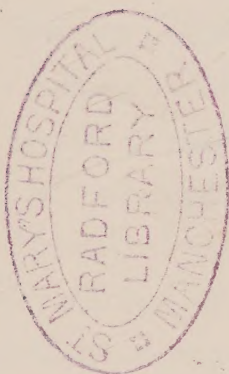
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PROCEEDINGS  
OF THE  
MEDICAL SOCIETY  
OF  
LONDON.



VOL. II.  
1874 — 1875.

LONDON:  
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## P R E F A C E.

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IN submitting the second volume of the Society's 'Proceedings' to the Fellows it is expedient to premise by stating that it has been a source of regret to your Council that these 'Proceedings,' which should have been ready in October, have been delayed to the present time. But the Council were in no way at fault, prudential motives making such a course imperative. One of the Society's tenants was in arrears of rent, and it was thought wise to delay publication until these outstanding claims could be adjusted. By the activity of the Executive Committee, however, and the assiduity of the Society's solicitor, at last all was satisfactorily arranged, and the 'Proceedings' were printed. To the two Secretaries, Dr. Theodore Williams and Mr. Richard Davy, the credit is entirely due that they appear in their present complete form, and to them, therefore, the best thanks of the Society are due. It is quite true that these 'Proceedings' are simply abstracts, the papers themselves having, for the most part, been published in full elsewhere. But as these abstracts are very full and mostly prepared by the authors themselves, they may be said to convey their information in the manner most desired by the authors, and in character most likely to prove useful to the Fellows. The original researches, the practical nature and extensive scope of many of these papers, are faithful evidences of the marked usefulness of the Society and the untiring zeal of the

## PREFACE.

Fellows in the pursuit of science, and bids fair to still greater prosperity in the future.

Together with these 'Proceedings' the new code of Amended Laws is printed, so that members may find in a small compass all the information needed ; the perusal of which, setting forth as they do the high objects of the Society and its social character, it is believed will lead to large future accession of Fellows.

C. H. F. ROUTH, *President.*



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Subject for the Fothergillian Gold Medal for March, 1876:  
 "On Cataract and its Treatment." For March, 1877: "On  
 Pyæmia."

N.B.—Essays competing for the prizes are to be sent in before  
 the 1st of the preceding November.



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## L A W S

OF THE

# MEDICAL SOCIETY OF LONDON

*(Revised in 1875).*

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**Of the Objects of the Society and of the Fellows.**—1. The Medical Society of London, founded in 1773, has for its objects the advancement of the science and art of Medicine in all its branches, and the cultivation of good fellowship among its practitioners.

2. The Society shall consist of Fellows, Honorary Fellows, and Corresponding Fellows.

3. Members of the medical profession residing in Great Britain and Ireland shall be eligible as Fellows.

4. Distinguished members of the medical profession, and persons eminently skilled in other departments of science connected with medicine, shall be eligible as Honorary Fellows.

5. Members of the medical profession residing abroad shall be eligible as Corresponding Fellows.

6. Every candidate for the Fellowship shall be recommended by three Fellows, to one of whom, at least, he is personally known, and shall be elected by ballot.

7. The recommendation shall be read by the President at an Ordinary Meeting, and shall be suspended in the Library until the next meeting but one afterwards, when the ballot shall take place. No person shall be declared elected unless three fourths of the votes are in his favour.

8. Each Fellow shall be admitted at an Ordinary Meeting, when, having paid his entrance fee, he shall sign the following obligation, viz.:

*We, whose names are hereunto subscribed, promise that we will observe the Laws and Regulations of the Medical Society of London, and endeavour to promote its honour, so long as we shall continue Fellows thereof.*

The President shall then take him by the hand and say, "In the name and by the authority of the MEDICAL SOCIETY OF LONDON, I admit you a Fellow thereof."

9. Honorary and Corresponding Fellows shall be elected in the same manner as Fellows, except that the recommendation shall be made by the Council. They shall not be entitled to hold office, or to take part in the management of the Society.

10. Fellows who have resigned may be readmitted on their application for that purpose, upon such terms as the Council may think proper.

11. Every Fellow shall, on admission, pay One Guinea as his entrance fee, and One Guinea as his annual subscription. Corresponding Fellows shall pay One Guinea on admission. Honorary Fellows shall not be required to pay either entrance fee or subscription.

12. All yearly subscriptions shall be due in advance in October. Fellows elected in the months of March or April shall not be required to pay a subscription until the October following.

13. Every Fellow who shall not have paid his subscription on the first day of October following that on which it was due shall have notice to that effect given him by the Secretaries in writing; if at the end of six months from that time the subscription be still unpaid, the name of the Fellow shall be suspended in the Library; and if after the expiration of a further period of six months the subscription has not been paid, the Council shall have power to erase the name of such defaulting Fellow from the list of the Fellows of the Society.

14. A Fellow who shall pay the sum of Ten Guineas in addition to any entrance fee and subscription then due shall be exempted from all further payments.

15. A Fellow may withdraw from the Society by giving notice to that effect, in writing, to the Council, and paying all moneys due by him to the Society.

16. A Fellow may be expelled from the Society for due cause, the proceeding for which shall be as follows:—A written notice of the proposed expulsion and the reasons for the same, signed by two Fellows of the Society, having been delivered to the Honorary Secretaries, they shall immediately forward a copy thereof to the Fellow concerned, with a request that he will reply thereto, and shall at the same time summon the Council to meet within fourteen days to consider the matter. If the Council resolve by a majority of those present at the meeting that there are grounds for further proceedings, a Special Meeting of the



Fellows shall be convened, when, if three fourths of the Fellows voting are of opinion that the Fellow in question shall be expelled, the President shall direct his name to be erased from the List of the Fellows of the Society.

**Of the Officers and Councillors.**—17. A President, four Vice-Presidents, a Treasurer, a Librarian, three Secretaries, an Orator, and twenty other Fellows, shall be chosen annually from the Fellows by ballot, and, together with the Trustees, shall constitute the Council.

18. The President, the two senior Vice-Presidents, and the ten Councillors who have attended the fewest meetings of Council, shall not be eligible for re-election for one year.

19. No Officer or Councillor (except the Trustees) shall hold the same office for more than three years consecutively.

20. The ballot shall take place, between 7.30 p.m. and 8.30 p.m., at the First General Meeting of the Society, a special summons having been sent to each Fellow at least seven days before, enclosing the balloting list.

21. The balloting list shall consist of three columns—one containing the names of present Officers and Members of the Council, denoting those who are ineligible for re-election; a second containing a list of persons recommended for office by the Council; and a third with blank spaces, in any of which Fellows may write the name of a Fellow they may select for office in the place of the corresponding one recommended by the Council.

22. Every Fellow balloting shall give his name to the President, and afterwards put his list into the balloting box, but if any Fellow be unable to attend personally he may return his list, enclosed in a sealed envelope but not signed, with his name inscribed therein, to the President, at the Society's House, on or before the day of election. This list, with its seal unbroken, the President shall deposit in the balloting box. At the close of the ballot the box shall be delivered by the President to an Officer and three Scrutineers then appointed by the Fellows, who shall report the result to the meeting.

23. In the event of an equality of votes the President shall determine by lot.

24. The Council shall have the power of filling up any vacancies occurring between the Annual Meetings.

**Of the President and Vice-Presidents.**—25. The President shall regulate all the proceedings of the Society, shall state and put questions, admit Fellows, interpret the application and enforce the observance of the Laws, check irregularities, decide every doubtful point, and have a second vote when the suffrages are equal. He shall sign the minutes

of the meetings, and shall present the thanks of the Society to contributors and donors.

26. Any decision of the President may be referred to the Council on the written demand of three Fellows; such demand to be at once given in, and read from the Chair.

27. In the absence of the President the Chair shall be taken by a Vice-President, or other Member of the Council.

**Of the Treasurer.**—28. The Treasurer shall receive all money due to the Society, and shall pay it into a bank appointed by the Council. He shall make all payments ordered by the Council by cheque signed by himself and one of the Secretaries; he shall keep an account of all such receipts and payments, and shall report the same to the Council at each Monthly Meeting.

29. The Treasurer shall keep a numbered printed receipt book for the entrance fees and subscriptions, in which, and on the counterfoil, full particulars shall be entered by the Collector. Receipts shall be signed by the Treasurer and countersigned by the Collector; counterfoils shall be signed by the Collector.

30. The Treasurer shall present a Report of the Income and Expenditure of the Society to the first General Meeting in each year. The Report shall be laid before the first Council Meeting in February, and shall be audited by two Fellows appointed at that time.

**Of the Librarian.**—31. The Librarian shall, with the assistance of the Library Committee, inspect the Library at least once annually, and shall report its condition to the first General Meeting in each year. He shall enforce the observance of the laws relating to the Library, and shall be, *ex officio*, a Member and the Chairman of the Library Committee.

**Of the Secretaries.**—32. There shall be three Secretaries; two in ordinary, and one for foreign correspondence.

33. The Secretaries in ordinary shall manage the correspondence of the Society, and of the Council. They shall receive all papers intended for the use of the Society. One of them shall attend every meeting of the Society and of the Council, shall take minutes of the proceedings, read those of the previous meeting, and see that a complete copy of the Laws and a list of the Fellows be on the table. They shall send notices of Council Meetings to every Councillor, stating the business of the meeting, at least three days beforehand. They shall also send notices of all extraordinary meetings of the Society, or of the Council, and shall transact such other business as the Council may direct.

34. The Secretary for Foreign Correspondence shall write all letters to Corresponding Fellows, or persons resident abroad. He shall



provide the Council with translations of any foreign letters or papers received, and with such foreign medical or scientific information as he may see fit.

35. The Secretaries shall be, *ex officio*, Members of all Committees.

**Of the Trustees.**—36. The Library, Museum, Furniture, Fixtures, Stock in the public funds, and all other property of the Society, including that known as the Fothergillian Fund, shall be invested in the hands of at least three Trustees, to be elected by the Council, in trust for their respective uses and purposes. The Trustees shall not be held responsible for any damage or loss whatsoever that may befall or happen to the Books, or Furniture, or other effects of the Society.

37. Any Fellow holding the office of Trustee shall on his resignation of or on his removal from the Fellowship of the Society, or on his discontinuing to reside within ten miles of London, cease to be a Trustee.

38. Within one calendar month after the death, resignation, disqualification, or removal beyond ten miles of London of any of the Trustees, the Council shall proceed to elect a new Trustee in the place of the one so dying, resigning, or becoming disqualified, and shall forthwith take such measures as may be necessary to transfer the property into the name of the new Trustee jointly with the surviving Trustee or Trustees, or solely, as the case may be.

39. The several Trustees shall be, *ex officio*, Members of Council.

N.B.—Laws 36, 37, and 38 do not apply to the Trustees of the Bolt Court property, who are appointed under the provisions of Dr. Lettsom's will.

**Of the Council.**—40. The Council shall have the management of the affairs of the Society. It shall choose annually from its members two Chairmen, who shall preside alternately. It shall meet on the first Friday of every month, except, June, July, and August, at 8.30 p.m., or at any other hour named in the summons, and shall have the power of adjourning to any future day. When the first Friday of the month is Good Friday the meeting shall be held on the second Friday. Five Members shall form a quorum. Special Meetings may be called by the President, or by any three Members of the Council, three days' notice at least being given. The proceedings of the Council shall be recorded in a minute-book.

41. Each Member of the Council shall, before entering the Council Room and taking part in the proceedings, sign his name in a book kept for that purpose.

42. The Council shall appoint the Library Committee, the Committee of Referees, the Fothergillian Medal Committee, the Lettsoman Lec-

turer, and the Orator at its first meeting in each year; the Auditors at its first meeting in February; and the Trustees, the Registrar, and the Collector as the offices fall vacant. It shall also determine the subject for the Fothergillian Gold Medal. The Council shall have power to appoint, at any time, any Committees, sectional or otherwise, that it may think desirable, and to appoint on such Committees any Fellows of the Society, whether Members of Council or not. The Council shall present to the first General Meeting of the Society in each year a report on the general condition of the Society.

**Of the Registrar.**—43. The Registrar shall be appointed by the Council, who shall regulate his duties and fix his salary. He shall have charge of the Library under the direction of the Librarian.

**Of the Collector.**—44. The Collector shall be appointed by the Council, and shall receive a poundage upon all subscriptions collected by him. He shall give such securities to the Trustees for the performance of his duties as shall be satisfactory to the Council.

45. He shall keep a record of all Fellows in arrear, and shall inform the Treasurer when any Fellow has neglected to pay his subscription.

46. He shall give to the Treasurer, previously to the meetings of the Council in every month, an account of his receipts.

**Of the Lettsomian Lectures.**—47. The Council shall annually at its first meeting appoint a Fellow of the Society to give the course of lectures called the Lettsomian Lectures, not exceeding three in number, on some subject in connection with Medical Science.

48. The Lectures may be given at the Ordinary Meetings, or on such other evenings as the Council may from time to time determine.

**Of the Oration.**—49. The Council shall annually at its first meeting appoint a Fellow to deliver an Oration on the Monday after the last Ordinary Meeting of the session, at 8.30 p.m. The Oration shall be followed by a *Conversazione*.

**Of the Library.**—50. All Books, Periodicals, Plates, Maps, and Tables shall, immediately on being received, be stamped on the title-page by the Registrar, with the Society's stamp. The weekly and monthly periodicals shall lie upon the Library table for a fortnight, the quarterly and half-yearly periodicals for one month, and new works for a week; after which they shall be entered in the Catalogue, placed in the Library, and circulated under the usual regulations.

51. The books of the Library shall be properly arranged, and each volume distinctly marked. An alphabetical catalogue shall be kept by the Registrar of all books, describing the edition, the place of publi-

cation, the date and size, and the place in the Library. Catalogues or Appendices shall, from time to time, be printed by the order and under the inspection of the Council.

52. The Library shall be open daily, except on Sundays, on Bank Holidays, and for such period between the first day of August and the last day of September as the Council may determine. The hours shall be from 1 p.m. to 6 p.m., except on Saturdays, when they shall be from 1 p.m. to 3 p.m.

53. Any Fellow who shall injure, or remove from the Society's house, any periodical or new publication, during the time allotted for its lying upon the Library table, shall incur a fine of five shillings for every such offence.

54. Fellows residing within the Metropolitan Postal District shall be permitted to take books from the Library on signing a receipt. Four volumes only shall be allowed to a Fellow at the same time unless with the leave of the Librarian, who shall have power to extend the number to ten. The title of each work borrowed and the name of the Fellow obtaining it shall be entered in a book by the Registrar, and the entry shall be cancelled and the volume restored to its place immediately on its return.

55. When a book has been a fortnight in the possession of a Fellow he may be required to return it by notice from the Registrar that it is needed by another Fellow, and a fine of sixpence a day shall be incurred for every day the book is detained beyond the third day from the postage of the notice.

56. Fellows shall be supplied with books in the order of their application.

57. No Fellow shall be entrusted with the keys of the Library, nor be allowed to take down books unaccompanied by the Registrar.

58. No Fellow shall lend a book to any person, under a penalty of half a guinea.

59. The Registrar shall be answerable for all books for the absence of which he cannot satisfactorily account.

60. Any Fellow who loses or injures a book, shall, within a month after such default, replace it, or pay the value of the set, if there be more than one volume.

61. No book shall be taken from the Library during the last fortnights of February. The Registrar shall give notice to Fellows who have books in their possession that they must be returned within a fortnight. A fine of two shillings and sixpence for each volume shall be incurred for neglect to comply with this notice.

62. The Council shall, at its first meeting, appoint four Fellows, who, with the Librarian, shall constitute a Library Committee (two to form a quorum), to recommend to the Council such books as they deem proper



to be ordered, and generally to supervise the Library. The Committee shall meet at least three times a year.

63. A book shall lie on the Library table, in which Fellows may write the titles and price of such publications as they may recommend for purchase.

64. The donor's name shall be entered in every work presented to the Society.

65. The Council shall designate such manuscripts and books of value as shall not be taken out of the Library without the permission of the Librarian.

66. No further issue of books shall be allowed to a Fellow who has not paid all fines that he may have incurred.

**Of the Meetings.**—67. The *Ordinary Meetings* shall be held, at 8.30 p.m., on each Monday, from the third Monday in October to the first Monday in May inclusive, with the exception of the eighth day of March, when it falls on a Monday, and the last Monday of each year. On the days of the first and third General Meetings the Ordinary Meeting shall commence when the business of the General Meeting has been concluded. Additional meetings may be held when the Council think proper.

68. Each Fellow shall, before entering the room, sign his name in a book kept for that purpose. He may introduce two Visitors at each Ordinary Meeting of the Society, on entering their names in the Visitors' Book; no Visitor shall be admitted more than twice during the Session, unless by the permission of the President.

69. At the Ordinary Meetings the business shall be conducted in the following order:

- a. The minutes of the last meeting shall be read and confirmed.
- b. Candidates proposed at the last meeting shall be balloted for.
- c. Recommendations of Candidates shall be read, and notice of the time of the ballot for their election shall be given.
- d. Fellows elected at this or former meetings shall sign the obligation, and be formally introduced to, and admitted by the President.
- e. The names of Visitors admitted for the evening shall be announced from the Chair. They shall be invited to take part in the discussion.
- f. Communications to the Society shall be made, and in such order as the President may direct; short reports of cases, exhibition of patients and of pathological specimens being, as far as possible, taken during the early part of the meeting.
- g. The chief communications for the next meeting shall be announced.

*h.* At ten o'clock precisely the President shall adjourn the meeting, unless a special resolution be passed to extend the discussion for half an hour longer.

70. Communications to the Society shall relate only to subjects connected with Medical Science, and shall not exceed in length what may be read in half an hour. They shall be read either by the author or by one of the Secretaries, and the Fellows shall be at liberty to make observations upon them.

71. Notice of a proposed communication must be given to one of the Secretaries and an abstract for publication in the medical journals must be furnished by the author. The President shall have power to refer any proposed paper to the Committee of Referees for a report as to its suitability; but an adverse report shall not be acted upon except by order of the Council. Whenever practicable the titles of communications and some account of their nature shall be suspended in the Library prior to their being read.

72. The discussions at the Ordinary Meetings shall be strictly confined to the communications of the evening. All matters relating to appeals, the expulsion of Fellows, or other extraordinary business, shall be transacted only at Special Meetings.

73. No Fellow shall be entitled in a discussion to speak more than once, except in explanation, or for a longer time than ten minutes; but the author of a communication shall have a right to reply thereon.

74. A copy of the Statutes and the Insignia of the Society shall lie on the table, before the President, at all meetings.

**Of the General Meetings.**—75. There shall be three General Meetings in every year; the first on the Monday preceding the 8th of March, at 7.30 p.m.; the second, the Anniversary, on the 8th of March, and the third on the first Monday in November, at 8.30 p.m.

76. At the first General Meeting the Officers and Council shall be elected; a Report of the state of the Society shall be presented by the Council, of the Finances by the Treasurer, and of the Library by the Librarian. The subject of the essay for the Fothergillian Medal shall be announced.

77. The Anniversary Meeting shall be celebrated by a Dinner at such time and place as the Council may determine; during the evening the names of the Officers and Council elected for the ensuing year shall be announced, and the Medals which have been awarded shall be presented by the President.

78. At the third General Meeting alterations of or additions to the Laws of the Society may be made.

79. A Special General Meeting may be called by the President and

Council at any time; six days' notice thereof and of the matter to be considered must be sent to each Fellow.

**Of the Appeals and Special Meetings.**—80. The Fellows have the right of appeal from any act of the Council to the Society at large.

81. An appeal to the Society must be signed by at least six Fellows, and delivered at an Ordinary Meeting before nine o'clock to the President, who shall read it from the Chair; should the appeal not be withdrawn before nine o'clock at the ensuing Ordinary Meeting, the President shall then take the sense of the Meeting whether or not a Special Meeting shall be convened for its consideration. The time at which the meeting shall be held shall be determined by the votes of the Fellows present.

82. The Fellows, when assembled in Special Meeting, shall have full power to determine all questions submitted to them, but no subject shall be considered of which notice has not been given in the requisition.

**Of the Making and Repealing Laws.** 83.—Except as hereinafter provided, new Laws shall be made, and old ones repealed or altered, only at the third General Meeting of the Society, or at such Special General Meeting as shall be summoned for the purpose. All proposed changes must be suspended in the Library for a fortnight before the meeting. No alteration of the Laws shall be valid unless two thirds of the Fellows voting ballot in its favour.

84. The Council shall nevertheless, when special need exists, have power to make alterations in the Laws of the Society, or new Laws, at other times in the following manner:—The alteration, or the new Law, having been agreed upon by the Council, the same shall be read to the Society from the Chair, before nine o'clock, at four successive Ordinary Meetings; and, having been suspended during the interval in the Library, shall become a Law of the Society, when it has been thus four times publicly read, without an appeal being lodged against it. If, however, an appeal, signed by at least six Fellows, be delivered to the President at any of the four meetings above named, he shall convene a Special Meeting for the consideration of the matter, according to the usual form.

**Of the Medals.**—85. The Society offers, annually, to the author of the best dissertation on a subject proposed, a GOLD MEDAL, value twenty guineas, called the Fothergillian Medal, for which the learned of all countries are invited to become candidates; if in any year it should be the opinion of the Committee appointed for the adjudication of this Medal that no one of the dissertations presented to the Society, is of



sufficient merit, the Council shall have power to suspend the award of the Medal.

86. The subject for this Medal shall be determined by the Council, and announced at the first General Meeting of the Society in each year.

87. Each dissertation shall be written in English or Latin, and shall be delivered to the Registrar, on or before the first day of November, in the year subsequent to that in which the subject is announced.

88. With the dissertation shall be delivered a sealed packet, having on the outside a motto or device, and within, the author's name and designation ; the same motto or device shall be written on the dissertation.

89. No dissertation in the handwriting of the author, or with his name affixed, shall be received ; if the author shall become known to the Committee, or to any member thereof acting thereon, his dissertation shall be excluded from competition.

90. The successful dissertation shall be the property of the Society, but the Council shall have the power of permitting the author to publish it ; the unsuccessful dissertations shall be returned, if applied for within twelve months, with the sealed packets unopened.

91. All unsuccessful dissertations, not reclaimed within twelve months shall be disposed of in such manner as the Council may think proper.

92. The Medal shall be presented to the successful candidate, or to his substitute, at the Anniversary Meeting.

93. The prize dissertation, or an abstract of it, shall be read before the Society on the evening of the first General Meeting.

94. The Council shall, at its first meeting, appoint seven Fellows as an Adjudication Committee, to which all dissertations shall be referred, and which shall decide by ballot upon their respective merits.

95. The Council shall have power to award annually two *Silver Medals*, for an essay or essays written by a Fellow, Honorary or Corresponding Fellow, or by any person not a Fellow of the Society, and read before the Society, or for any special services rendered to the Society by a Fellow.

**Of Papers.**—96. Twenty Fellows of the Society shall be appointed by the Council to constitute a Committee of Referees, who shall, when requested by the President, report, confidentially to the Council, on the fitness of any of the papers intended for the use of the Society, and, previously to the adjudication of the Silver Medals, shall report to the Council on the comparative merits of the papers submitted for their opinion.

**Of Transactions.**—97. The Council shall have power to publish the

proceedings of the Society at such times and in such form as it may think fit. Each Fellow shall be entitled to a copy.

**Of Donations to the Society.**—98. Any person who shall present to the Society books, money, or other valuable property, shall, on the recommendation of the Council, receive the thanks of the Society; and the name of the donor and of the gift shall be entered on the minutes, and announced at the next Ordinary Meeting of the Society.

**General Laws.**—99. When the determination of the Society is required on a question, it shall be taken by ballot, if so demanded by any Fellow.

100. All questions, excepting those for which it is otherwise provided, shall be determined by a majority of the Fellows present.

## Past Presidents of the Society.

---

			ELECTED
JOHN MILLAR, M.D.	...	...	1773
JOHN C. LETTSOM, M.D.	...	...	1775
NATHANIEL HULME, M.D.	...	...	1776
GEORGE EDWARDS, M.D.	...	...	1779
SAMUEL F. SIMMONS, M.D.	...	...	1780
JOHN SIMS, M.D.	...	...	1783
JOHN WHITEHEAD, M.D.	...	...	1784
JOHN RELPH, M.D.	...	...	1785
JAMES SIMS, M.D.	...	...	1786
J. C. LETTSOM, M.D.	...	...	1809
GEORGE PINCHARD, M.D.	...	...	1811
J. C. LETTSOM, M.D.	...	...	1813
JOSEPH ADAM, M.D.	...	...	1815
THOMAS WALSHMAN, M.D.	...	...	1817
HENRY CLUTTERBUCK, M.D.	...	...	1819
DAVID UWINS, M.D.	...	...	1821
WILLIAM SHEARMAN, M.D.	...	...	1823
HENRY CLUTTERBUCK, M.D.	...	...	1825
JOHN HASLAM, M.D.	...	...	1827
THOMAS CALLAWAY	...	...	1829
JOHN BURNE, M.D.	...	...	1831
WILLIAM KINGDON	...	...	1833
JOHN WHITING, M.D.	...	...	1835
THOMAS E. BRYANT	...	...	1837
LEONARD STEWART, M.D.	...	...	1839
HENRY CLUTTERBUCK, M.D.	...	...	1840
GEORGE PILCHER	...	...	1842
THEOPHILUS THOMPSON, M.D.	...	...	1844
WALTER COOPER DENDY	...	...	1846
HENRY HANCOCK	...	...	1848
JOHN RISDON BENNETT, M.D.	...	...	1850



			ELECTED
E. W. MURPHY, M.D.	...	...	... 1851
JOHN BISHOP, F.R.S.	...	...	... 1852
FORBES WINSLOW, M.D., D.C.L.	...	...	... 1853
EDWARD HEADLAND	...	...	... 1854
JOHN SNOW, M.D. ...	...	...	... 1855
W. D. CHOWNE, M.D.	...	...	... 1856
FRANCIS HIRD ...	...	...	... 1857
W. H. WILLSHIRE, M.D.	...	...	... 1858
JOHN HILTON, F.R.S.	...	...	... 1859
ALFRED B. GARROD, M.D.	...	...	... 1860
WILLIAM COULSON	...	...	... 1861
FRANCIS SIBSON, M.D., F.R.S.	...	...	... 1862
EDWIN CANTON ...	...	...	... 1863
ROBERT GREENHALGH, M.D.	...	...	... 1864
I. B. BROWN ...	...	...	... 1865
CHARLES J. HARE, M.D.	...	...	... 1866
HENRY SMITH ...	...	...	... 1867
BENJAMIN W. RICHARDSON, M.D., F.R.S.	...	...	... 1868
PETER MARSHALL	...	...	... 1869
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S. O. HABERSHON, M.D.	...	...	... 1873
VICTOR DE MÉRIC	...	...	... 1874

# Medical Society of London,

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*Elected at the General Meeting, March 1st, 1875.*

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## Past Lettsomian Lecturers.

(THE LETTSOMIAN LECTURES COMMENCED IN 1851.)

### SESSION

- |         |  |
|---------|--|
| 1850-51 | { G. OWEN REES, M.D., F.R.S., "On some of the Pathological Conditions of the Urine."<br>G. J. GUTHRIE, F.R.S., "On some of the more Important Points of Surgery."  |
| 1851-52 | { FORBES WINSLOW, M.D., "On Medico-legal Evidence in Cases of Insanity."<br>HENRY HANCOCK, F.R.C.S., "On the Anatomy and Physiology of the Male Urethra and on the Pathology of Stricture of that Canal."                                    |
| 1853-54 | E. W. MURPHY, M.D., "On Parturition as Illustrating the Importance of a Competent Education in the Practice of Midwifery."   |
| 1854-55 | { THEOPHILUS THOMPSON, M.D., "On Pulmonary Consumption."<br>JOHN BISHOP, F.R.S., "On the Physical Constitution, Diseases and Fractures of Bones."  |
| 1854-55 | { FRANCIS SIBSON, M.D., F.R.S., "On the Influence of the Nervous System on Respiration and Circulation."<br>FRANCIS HIRD, "On some Special Points in the Anatomy of the Uterus, and its Structural Lesions the Result of Inflammation."      |
| 1855-56 | None.  |
| 1856-57 | ALFRED B. GARROD, M.D., F.R.C.P., "Illustrations of the Pathology and Treatment of Gout."  |
| 1857-58 | { ROBERT BARNES, M.D., "On the Physiology and Treatment of Flooding from Unnatural Position of the Placenta."<br>EDWIN LANKESTER, M.D., "On the History, Symptoms, and Treatment of Intestinal and other Worms Parasitic on the Human Body." |
| 1858-59 | { FREDK. HEADLAND, M.D., "On the Advance during Modern Times of the Science of Medical Treatment."<br>VICTOR DE MÉRIC, "On Syphilis."  |
| 1859-60 | { F.W.PAVY, M.D., F.R.S., "On Certain Points connected with Diabetes."<br>ANDREW CLARK, M.D., "On Certain Evidences of the Arrestment of Phthisis."  |
| 1860-61 | { C. J. HARE, M.D., "Practical Observations on some of the Points of Difficulty in the Investigation of Tumours and Intumescence of the Abdomen."<br>HAYNES WALTON, "On the Application of the Ophthalmoscope, and its Advantages."          |

## SESSION

- 1861-62 { B. W. RICHARDSON, M.D., F.R.S., "On Certain of the Phenomena of Life."  
F. W. MACKENZIE, M.D., "On the Pathology and Treatment of Phlegmasia Dolens."
- 1862-63 { HENRY THOMPSON, "On Practical Lithotomy and Lithotrity."  
JAMES BIRD, M.D., "On Public and Private Hygiene."
- 1863-64 { THOMAS BRYANT, "On the Surgical Diseases of Children."  
C. H. F. ROUTH, M.D., "On some Points connected with the Pathology, Differential Diagnosis, and Treatment of Fibrous Tumours of the Uterus."
- 1864-65 { HENRY SMITH, "On the Surgery of the Rectum."  
J. L. W. THUDICHUM, M.D., "On Medicine: The Progress of Urology, with Practical Illustrations of its Value in the Diagnosis and Treatment of Several Diseases."
- 1865-66 F. E. ANSTIE, M.D., "On Certain Painful Affections of the Fifth Nerve."
- 1866-67 JOHN GAY, "On Varicose Diseases and Ulcers of the Lower Extremities."
- 1867-68 GEORGE BUCHANAN, M.D., "On the Diagnosis and Management of Lung Diseases in Children."
- 1868-69 WILLIAM ADAMS, "On Rheumatic and Strumous Diseases of the Joints, and the Treatment for the Restoration of Motion in Partial Ankylosis."
- 1869-70 TILBURY FOX, M.D., "Eczema: its Nature and Treatment."
- 1870-71 FRED. J. GANT, "On Excisional Surgery of the Joints; the Conditions appropriate for Excision; the Operations; After Treatment and Results."
- 1871-72 S. O. HABERSHON, M.D., "On the Pathology and Treatment of some Diseases of the Liver."
- 1872-73 HENRY LEE, "Urethral Discharges."
- 1873-74 W. H. BROADBENT, M.D., "On Syphilitic Affections of the Nervous System."
- 1874-75 C. F. MAUNDER, "On the Surgery of the Arteries."
- 1875-76 C. T. WILLIAMS, M.D., "The Influence of Climate in the Treatment of Pulmonary Consumption."



## The Orators.

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1859	A. T. H. WATERS.
1868	JOHN CLAY.
1870	T. S. CLOUSTON, M.D.
1872	EDWARDS CRISP, M.D.
1874	J. K. SPENDER, M.D.



## Honorary Fellows.

---

ASHBURNER, J., M.D. (1825). P.

BENNETT, J. RISDON, M.D. (1837 ; FM 1842), 15, Finsbury-square, Consulting Physician to St. Thomas's Hospital, and Physician to the Victoria-park Hospital. P 2, VP 2, C 7, O, S 3, ‡ 8.

BURROWS, Sir GEORGE, Bart., M.D., D.C.L., F.R.S., 18, Cavendish-square, W., President of the Royal College of Physicians ; Physician in Ordinary to H.M. the Queen ; Consulting Physician to St. Bartholomew's Hospital ; Member of the Senate of the University of London.

CHAUVEAU, Professor, Lyons.

CHRISTISON, Sir ROBERT, Bart., M.D., D.C.L., LL.D., 40, Moray-street, Edinburgh, Physician in Ordinary to H.M. the Queen in Scotland ; President of the Royal Society of Edinburgh ; Professor of Materia Medica in the University of Edinburgh.

COULSON, W., F.R.C.S. (1843), 2, Frederick-place, Old Jewry, Consulting Surgeon to St. Mary's Hospital and to the German Hospital. P, VP, C, S, ‡.

FARRE, ARTHUR, M.D., F.R.S., 12, Hertford-street, Mayfair, W., Physician-Accoucheur to H.R.H. the Princess of Wales.

FISHER, Sir J. W., Kt., M.D. (1807), 33, Park-lane, W. P 2, VP.

GUENEAU DE MUSSY, NOEL, M.D., Rue St. Arnaud, Paris.

HANCOCK, HENRY, F.R.C.S. (1838), Standen House, Chute, Wilts, Senior Surgeon to Charing Cross Hospital. P 4, VP 5, C 8, LL, O, T 8, ‡ 14.

HARE, CHARLES J., M.D., F.R.C.P., 57, Brook-street, W., late Professor of Clinical Medicine in University College, and Physician to University College Hospital, &c. P, VP 2, C, 8, LL, ‡ 8, || 2. (*Trustee.*)

HAWKINS, CÆSAR, Esq., F.R.S., 26, Grosvenor-street, Sergeant-Surgeon to H.M. the Queen, and Consulting Surgeon to St. George's Hospital, &c. C 2, S.

HAWKINS, F., M.D., 16, Ashley-place, Victoria-street, S.W., Registrar of the General Medical Council, Physician to the Queen's Household.

HEBRA, FERDINAND, M.D., Professor of Dermatology in the University of Vienna.

HELMHOLTZ, H., M.D., Berlin, Professor of Physiology in the University of Berlin.

- \*HILTON, JOHN, F.R.S., F.R.C.S. (1845), 10, New Broad-street, E.C., Consulting Surgeon to Guy's Hospital; Surgeon-Extraordinary to H.M. the Queen. P, VP, C 3, ‡ 2, SM.
- HUXLEY, THOMAS HENRY, LL.D., F.R.S., 26, Abbey-place, St. John's Wood, N.W., Professor of Natural History in the Royal School of Mines.
- JENNER, Sir WILLIAM, Bart., M.D., K.C.B., D.C.L., F.R.S., 63, Brook-street, W., Physician-in-Ordinary to H.M. the Queen and to H.R.H. the Prince of Wales; Professor of Clinical Medicine in University College, London; and Physician to University College Hospital.
- JOHNSON, H. J., Esq. (1843), 9, Suffolk-place, Pall-mall East, and Roehampton, Surrey.
- LANGENBECK, BERNHARD VON, M.D., Berlin, Professor of Surgery in the University of Berlin.
- OLLIER, Professor, Lyons.
- OWEN, RICHARD, D.C.L., LL.D., F.R.S., Sheen Lodge, Mortlake, Superintendent of the Natural History Department in the British Museum.
- PAGET, Sir JAMES, Bart., D.C.L., F.R.S., 1, Harewood-place, Hanover-square, W., Sergeant-Surgeon-Extraordinary to H.M. the Queen; Surgeon-in-Ordinary to H.R.H. the Prince of Wales; Consulting Surgeon to St. Bartholomew's Hospital; Member of the Senate of the University of London.
- QUAIN, RICHARD, F.R.S., F.R.C.S. (1837), 32, Cavendish-square, Surgeon-Extraordinary to the Queen; Member of the General Council for the College of Surgeons; Emeritus Professor of Clinical Surgery, University College, and Surgeon to University College Hospital, &c. VP, C.
- ROKITANSKY, CARL, M.D., Vienna, Curator of the Imperial Pathological Museum, and Professor of the University of Vienna.
- SCANZONI, F. W. VON, M.D., Wurzburg, Professor of Midwifery in the University Wurzburg.
- SEAONE, M., M.D. (1835), Salamanca.
- SMITH, J. GREGORY, F.R.C.S., 23, Gloucester Place, Greenwich, S.E. VP, C 4.
- STOKES, WILLIAM, M.D., D.C.L., LL.D., F.R.S., 5, Merrion-square, Dublin, Regius Professor of Physic in Dublin University.
- TYNDALL, JOHN, LL.D., F.R.S., Professor of Natural Philosophy in the Royal Institution, Albemarle-street, Piccadilly, W.
- VIRCHOW, RUDOLPH, M.D., Berlin, Professor of Pathological Anatomy in the University of Berlin.
- WILLIAMS, C. J. B., M.D., F.R.S. (1838), Physician Extraordinary to H.M. the Queen; Senior Consulting Physician to the Brompton Hospital for Consumption. || 2.



## Corresponding Fellows.

*Prior to the Session 1868-9.**Elected*

- 1851 ALBARO, Sir D. J. MENDEZ, Madrid.
- 1861 ALVARENGO, PEDRO FRANCISCO DA COSTA, M.D., Lisbon.
- 1856 BAKER, ALBERT, M.D., Dawlish, Devonshire, Physician to the Dawlish Dispensary.
- 1855 BEARDSLEY, A., Esq., Bay Villa, Grange, Lancashire. ||.
- 1850 BENAVENTE, Sr. D. MARIANO, Madrid.
- BENEKE, F. W., M.D., New York.
- 1865 BOECK, Professor, Christiania.
- 1850 BÖHM, —, M.D., Vienna.
- BOTTANI, GIUSEPPE, M.D., Milan.
- BRANDER, J., M.D., India; in London, East India Club, St. James's-square.
- 1865 BRAUN, Professor CARL, Vienna, Physician to the General Lying-in Hospital.
- 1837 BÜHRING, J. J., M.D., Berlin.
- 1850 BURKE, J. PAGE, M.D., Staff Surgeon, R.N.
- CADE, THOMAS CHARLES, Esq., Spondon, Derby.
- 1855 CLARK, A., Esq., Twickenham.
- 1855 COATES, CHARLES, M.D., 10, Circus, Bath, Physician, Bath General and Royal United Hospitals.
- 1850 COX, WILLIAM J., Esq., Hawkesbury, Upton, Gloucestershire. c.
- 1850 CURTIS, GEORGE, Esq., Dorking.
- 1851 CUTLER, EDW., M.A., Spa, Belgium.
- 1851 CZERMAK, JOHN, M.D., Prague, Professor of Anatomy and Physiology.
- DE MUYNCK, J., M.D., Ghent.
- 1865 DIDAY, PAUL, M.D., Lyons.
- 1836 DE SA, MANOEL CARVALHO PEREIRA, M.D., Rio Janeiro.
- EKSTEIN, SIGISMUND, M.D., Vienna.
- 1851 ESCOLOR, Sr. D. SERAPIO, Madrid.
- EYLANDT, JOHANN EMIL, M.D., Curland, Russia.

*Elected*

- 1865 FALCONER, RANDLE WILBRAHAM, M.D., F.R.C.P., F.K.Q.C.P. (Ireland),  
22, Bennett-street, Bath, (Hon.) Senior Physician to the United and  
Mineral Water Hospitals.
- 1853 FALLOT, R., M.D., St. Laurant d'Aigonze, Montpellier, France.
- 1864 FEDETI, G., M.D., Rome.
- 1851 FLOR, Sr. D. JOSE PEREZ, Madrid.  
HARDING, GEORGE, Esq., East Indies, 37th Native Infantry, E.I.C.
- 1864 HASENFELD, EMMANUEL, M.D., Pesth.
- 1867 HUGHES, J. S., M.D., Dublin.  
HUGHES, ROBERT, F.R.C.S., Rose Hill, Barnstaple.
- HYMAN, —, M.D., Antwerp.
- 1851 IGUIERDO, Sr. D. SEBASTIAN OBTEGA, Madrid.  
JACKSON, J. M., Esq., Madras, E.I.C. Madras Light Infantry.  
JEYES, SAMUEL, M.D., Half-pay Staff.
- 1875 JONES, P. SYDNEY, M.D., College-street, Sydney, Australia.
- 1861 JOURNEZ, HENRI, M.D., 43, Rue de la Charité, Bruxelles, Belgique.
- 1852 JUNOD, THEODORE, M.D., Geneva.  
KITCHING, G., M.D., M.R.C.P., Enfield.
- 1851 KÖLLIKER, ALBERT, M.D., Wurzburg, Professor of Anatomy and Physio-  
logy.  
LAX, WILLIAM, Esq., Ormskirk, Lancashire, Surgeon to the Ormskirk  
Dispensary.
- 1876 LEIGHTON, JOHN, Lowell, Massachusetts.  
LEIGHTON, WALTER H., M.D., Lowell, Massachusetts, U. S. America.
- LEON, Sr. D. JOSE, Madrid.
- 1851 LLANOS, Sr. ANTONIO CAMPO, Madrid.
- 1851 LOVERA, Sr. D. JOSE, Madrid.
- 1851 MARINO, Sr. D. BONIFACIO MATEOS, Madrid.
- 1851 MENDEZ, Sr. D. BARTHOLOME, Madrid.
- 1849 MILLIGAN, J., Esq. (FM 1849), 1, South-street, Keighley, Yorkshire.
- 1851 MOLINA, Sr. D. M. M., Madrid.  
MOORE, GEORGE, M.D., M.R.C.P., M.R.C.S. (FM 1834), Hastings, ‡ 2.  
NASH, JAMES, M.D., High-street, Worcester, Consulting Physician to the  
Worcester Infirmary.
- NEFRI, GAETANO, M.D., Pisa.
- 1851 ORTEGA, Sr. D. J. R., Madrid.
- 1865 PERUZZI, DOMENICO, M.D., Senigaglia.
- 1851 PORTILLA, Sr. D. L. LUIS, Madrid.
- 1860 ROUSSELL, Dr., Dean of Faculty and Medicine at Montpelier.  
SAVERY, JOHN CHARLES, Esq., 12, York Buildings, Hastings.
- SCHARLAU, GUS. W., M.D., Stettin, Prussia.
- 1874 SCHUTGOWSKY, J., St. Petersburg.
- 1854 SEATON, Jos., M.D., F.R.C.P. (Edin.), F.R.G.S., Halliford House,  
Sunbury. ‡ 5.

*Elected*

- 1851 SESSE, Sr. D. M., Mesqui, Madrid.
- 1864 STOCKER, R. C. S., Esq., Chertsey.  
 STOCKWELL, THOMAS G., Esq., 9, Alfred-street, Bath.  
 STOLTERFOTH, SIGISMUND, M.D., F.R.C.P., Queen's-park, Chester.
- 1851 TERREZA, Sr. L. FELIX GARCIA, Madrid.  
 TERRY, H., F.R.C.S., Surgeon Extraordinary, General Infirmary, North-ampton.
- 1851 VALDEZ, Sr. D. FRANCO CORTIGO, Madrid.  
 WILLIAMS, CHARLES, Esq., 9, Prince of Wales-road, Norwich.  
 WILSON, CHARLES, M.D., Dalrymple Crescent, Grange, Edinburgh.



## GENERAL LIST OF FELLOWS OF THE SOCIETY.

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### EXPLANATIONS OF ABBREVIATIONS.

P.—President.

VP.—Vice-President.

T.—Treasurer.

L.—Librarian.

S.—Secretary.

C.—Councillor.

LL.—Lettsomian Lecturer.

FM.—Fothergillian Gold Medallist.

S.M.—Silver Medallist.

O.—Orator.

§—Sec. for Foreign Correspondence.

‡—Steward.

\*—Life Members.

||—Conversazione Steward.

The number prefixed (*e.g.* 1853) signifies the date of election.

The figures appended (*e.g.* s 2, c 3) indicate the number of Sessions served, and refer to past appointments ONLY.

NS.—Non-subscribing.

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*Alteration of Law.*—Every Fellow residing within the Limits of the London and Suburban postal districts, shall on admission pay one guinea as his entrance fee, and one guinea as his annual subscription; and every Fellow residing beyond the postal and Suburban postal districts shall pay one guinea as his annual subscription, but shall not be required to pay any entrance fee. All Subscribing Fellows shall equally enjoy all the privileges of Fellows.

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### *Elected*

1873 ADAMS, M. A., F.R.C.S., Maidstone, Kent.

1872 ADAMS, T. RUTHERFORD, M.D., Stamford House, Croydon. ||.

1852 ADAMS, WILLIAM, F.R.C.S., Surgeon to the Great Northern Hospital, 5, Henrietta-street, Cavendish-square, W. c 6, o 10, vp. 3, || 1, LL.

1868 AITKEN, WM., M.D., F.R.S., Woolston, Southampton. ||. NS.

1872 ALDRED, HENRY ALLEN, M.D., 7, Albemarle-street. ‡.

1873 ALEXANDER, REGINALD G., M.B., 13, Hallfield-road, Bradford, Yorkshire.

1873 ALLEN, H. MARCUS, M.R.C.P. Edin., 38, Regency-square, Brighton.

1873 ALLFREY, C. H., M.D., St. Mary's Cray, Kent. ||.

*Elected*

- 1872 ALLINGHAM, WILLIAM, F.R.C.S., 10, Chandos-street, Cavendish-square, Surgeon to St. Mark's Hospital for Diseases of the Rectum. ‡ 2.
- 1860 ALTHAUS, JULIUS, M.D., 18, Bryanston-street, Portman-square, W., Senior Physician to the Infirmary for Epilepsy and Paralysis. c 5, ‡ 1, §.
- 1871 AMBLER, VINCENT, F.F.P.S. Glasg., 14, Colville-square, Bayswater, W., Surgeon-Major 1st Surrey R.A.V. || 4, ‡.
- 1869 ARMITAGE, S. H., M.D., Huntriss-row, Scarboro.' NS.
- 1868 ARMSTRONG, JOHN, M.D., Dartford. NS.
- 1868 ARMSTRONG, JOHN CHRISTOPHER, Esq., Gravesend. NS.
- 1873 ARNOLD, HOWARD, Esq., 10, Lower Crescent, Belfast. NS.
- 1871 ARNOLD, WILBERFORCE, Esq., Belfast. NS.
- 1867 ASPRAY, CHARLES OWEN, M.D., F.R.C.S., Senior Surgeon to St. George's and St. James's Dispensary, 4, Devonshire-street, Portland-place, W.
- 1873 ATKINSON, EDWARD, Esq., F.L.S., 2, Albion-place, Leeds, Senior Surgeon to Leeds Public Dispensary.
- 1872 AVELING, JAMES H., M.D., 1, Upper Wimpole-street, W., Physician to the Chelsea Hospital for Women. ‡.
- 1873 BAGSHAW, FREDERIC, M.A., M.D., 5, Warrior-square, St. Leonards. ‡.
- 1871 BAILEY, GEORGE H., Esq., 9, Cavendish-place, W.
- 1873 BAILEY, JAMES J., Esq., Marple, Cheshire.
- 1868 BARDSLEY, Sir JAMES LOMAX, Kt., M.D., F.R.C.P., Greenheys, near Manchester. ‡. NS.
- 1859 BARNES, J. WICKHAM, F.R.C.S., 136, Gower-street, Bedford-square. ‡ 5, c 3, s 2, ||.
- 1871 BARRY, D. PATERSON, M.D., Twickenham. NS.
- 1874 BARRETT, HOWARD, Esq., 3, Tavistock-square, W.C.
- 1874 BARTLETT, JOSEPH JAMES HENRY, L.R.C.P., 35, Ladbroke-gardens, Notting-hill, Surgeon to Kensington Dispensary.
- 1868 BATEMAN, FREDERIC, M.D., Upper St. Giles-street, Norwich. NS.
- 1868 BEATTY, THOMAS CARLYLE, Esq., Seaham, Sunderland. NS.
- 1868 BELL, The Rev. DAVID, M.D., C.M., The Vicarage, Goole, Yorkshire. || (*Councillor*).
- 1867 BELL, H. ROYES, F.R.C.S., Exam., 44, Harley-street, W., Assistant-Surgeon to King's College Hospital. || 5, ‡ 6, c 3 (*Vice-President*), s, SM.
- 1872 BELL, JOHN H., M.D., Northampton. NS.
- 1872 BERKART, I. B., M.D., 71, Wimpole-street, W., Assistant-Physician to the City of London Hospital for Diseases of the Chest.
- 1873 BEVERIDGE, J. SPOWART, M.R.C.P. Ed., 4, Brunswick-ter., Kensington, W.
- 1868 BIRD, GEO., M.D., 49, Welbeck-street.
- 1850 BIRKETT, JOHN, F.R.C.S., 59, Green-st., Grosvenor-sq., W., Surgeon to, and Lecturer on Surgery at, Guy's Hospital. VP, c 6, ‡ 2, ||.
- 1860 BLOWER, WILLIAM, Esq., Bedford. NS.

*Elected*

- 1871 BLOXAM, JOHN ASTLEY, F.R.C.S., 8, George-street, Hanover-square, W., Assistant-Surgeon to the Charing Cross and West London Hospitals. 2, ||, ‡.
- 1868 BLOXAM, WILLIAM, M.D., 21, Mount-street, W. || 3, 2 ‡, c 2.
- 1867 BOND, THOMAS, M.B., B.S., F.R.C.S., 50, Parliament-street, S.W.
- 1864 BONNEY, F. A. BURDETT, Esq., Elm House Asylum, 149, Church-street, Chelsea, S.W. ‡ 2, || 2.
- 1871 BOTHWELL, G. G., Esq., Leighton Buzzard, Bedfordshire. NS.
- 1872 BOULTON, PERCY, M.D., Ed., 6, Seymour-street, Portman-square, W., Physician to the Samaritan Hospital.
- 1871 BOYD, ROBERT, M.D., F.R.C.P., 1, Bolton-row, W. ‡ 3.
- 1868 BRADY, JOHN, M.P., Ely, Cambs.
- 1868 BRAIDWOOD, P.M., M.D., Birkenhead. NS.
- 1869 BRAINE, WOODHOUSE, F.R.C.S., 56, Maddox-street, W. s 2, c, || 5, ‡ 5 (*Councillor*).
- 1873 BRIDGWATER, THOMAS, M.B., Medical Officer of the Harrow Dispensary. ‡.
- 1863 BROADBENT, W. H., M.D., F.R.C.P., 34, Seymour-street, Portman-square, W., Physician to St. Mary's and London Fever Hospitals; Lecturer on Medicine, St. Mary's Hospital Medical School. ‡ 3, c 4, || 4 (*Vice-President*), LL.
- 1871 BROWN, JOHN, Esq., 2, Rose-villas, Falcon-road, Clapham Junction, S.W., Medical Officer Battersea Dispensary.
- 1874 BROWN, JAMES DAWES, F.R.C.S., Haverfordwest, Surgeon to the Infirmary.
- 1871 BROWNE, J. CRICHTON, M.D., Wakefield. NS.
- 1873 BROWNE, LENNOX, Esq., 14, Weymouth-street, W., Surgeon to the Royal Society of Musicians. ‡ 3, || 2.
- 1873 BRUNJES, MARTIN, Esq., 42, Brook-street, Grosvenor-square, W. 2 ‡.
- 1862 BRUNTON, JOHN, M.A., M.D., Surgeon to the Royal Maternity Charity, 21, Euston-road, N.W. c ‡ 5, || 2 (*Chairman of Council*).
- 1874 BRUNTON, T. LAUDER, M.D., F.R.S., 23, Somerset-street, Portman-square, W., Assistant-Physician and Lecturer on Materia Medica at, St. Bartholomew's Hospital, Examiner in Materia Medica at, the University of London.
- 1850 BRYANT, THOMAS, F.R.C.S., 53, Upper Brook-street, W., Surgeon to Guy's Hospital. (*Councillor*), P, VP. 2, s 2, c 4, LL, ‡ 10, || 3.
- 1848 BRYANT, WALTER J., F.R.C.S., 23A, Sussex-square, Hyde-park-gardens, W. || 3.
- 1858 BUCHANAN, GEORGE, M.D., F.R.C.P., 24, Nottingham-place, Regent's-park, Assistant Medical Officer to the Local Government Board. c 2, LL., VP, ‡ 3, || 2 o.
- 1868 BUCKLE, FLEETWOOD, M.D., H.M.S., *Orontes*. NS.
- 1873 BUNNY, JOSEPH, M.D., Newbury, Berks, Coroner for the Borough.
- 1872 BURGER, ALEX., Esq., 6, King-street, Finsbury.



*Elected*

- 1874 BURNES, ALEX. GEO., M.B., C.M., 50, Green-street, Grosvenor-square, W.  
 1850 BURNIE, WM., M.D., Bradford. 2 ||. NS.  
 1868 BURROWS, Sir JOHN CORDY, F.R.C.S., Brighton. NS.  
 1872 BYAS, EDWARD Esq., H., 25, Belsize-park, Hampstead, N.W., and Grove Hall, Bow, E.
- 1867 CALTHROP, EDWARD, L.R.C.P., The Cheal, Hornsey-lane, N. ||.  
 1850 CAMPS, WM., M.D., Western-villas, Ealing. c 5, ‡ 17.  
 1839 CANTON, EDWIN, F.R.C.S. (FM 1857), 30, Montague-place, Russell-square, W.C., Surgeon and Lecturer on Surgery at Charing-cross Hospital; Surgeon to the British Museum. P, VP 2, c 6, LL, s, o, ‡ 12, ||.  
 1870 CARPENTER, ALFRED, M.D., High-street, Croydon. || (*Councillor*).  
 1873 CARR, WILLIAM, M.D., Lee-grove, Blackheath.  
 1871 CARTER, R. BRUDENELL, F.R.C.S. (Exam.), 69, Wimpole-street, W., Surgeon Royal South London Ophthalmic Hospital; Ophthalmic Surgeon to, and Lecturer on Ophthalmic Surgery at, St George's Hospital. o, ‡ 2, || 2 (*Councillor*).  
 1848 CARTWRIGHT, S., F.R.C.S., 32, Old Burlington-street, W., Professor of Dental Surgery, and Surgeon Dentist to King's College Hospital, London; Consulting Surgeon to the Dental Hospital of London. ‡ 9.  
 1865 CHAMBERS, THOS., M.R.C.P., Ed. F.R.C.S., 2, Bolton-row, Mayfair, and 2A, Sutherland-street, S.W., Physician to the Chelsea Hospital for Women, and Consulting Physician Accoucheur to the Western Dispensary, Westminster. || 2.  
 1867 CHAPMAN, JOHN, M.D., 25, Somerset-street, late Physician to the Farringdon Dispensary. ‡ 2.  
 1872 CHARLSLEY, W. P., M.D., Inspector General of Hospitals, Island of Ceylon. NS.  
 1868 CHESSELL, WILLIAM, M.D., Horley, Surrey. NS.  
 1868 CHILD, EDWIN, Esq., New Malden, and Coombe, Surrey. ‡ 4, || 2. NS.  
 1861 CHOLMELEY, W., M.D., F.R.C.P., 63, Grosvenor-street, W., Physician to the Great Northern Hospital, and to the Margaret-street Infirmary for Consumption; *Hon. Sec. for Foreign Corr.* c 5, ‡ 8, SM, o, || 3, VP.  
 1870 CHRISTIE, T. B., M.D., F.R.C.P., Royal India Asylum, Ealing, W. ||.  
 1871 CHURTON, THOMAS, Esq., Pier-road, Erith, S.E. ||, ‡ 2.  
 1874 CLAPTON, W., F.R.C.S., 42, Bloomsbury-square, W., Surgeon to West City Dispensary and Royal Humane Society.  
 1854 CLARK, ANDREW, M.D., F.R.C.P., 16, Cavendish-square, W., Physician to, and Lecturer on Clinical Medicine at, the London Hospital; Consulting Physician to the East London Hospital for Children. P, VP, c 5, LL, ‡ 5, || 5.

*Elected*

- 1875 CLARK, ANDREW, F.R.C.S., 14, Old Burlington-street, W., Assistant Surgeon, and Surgeon to Throat and Ear Department, Middlesex Hospital.
- 1873 CLARKE, T. KILNER, M.A., M.B., Huddersfield.
- 1870 CLOUSTON, T. S., M.D. (FM 1870), Superintendent Royal Asylum, Edinburgh. NS.
- 1874 CLOVER, J. T., F.R.C.S., 3, Cavendish-place, W. ||.
- 1873 CLUBBE, W. H., Esq., Lowestoft.
- 1869 COATES, WILLIAM MARTIN, Esq., Salisbury, Surgeon, Salisbury Infirmary. NS.
- 1849 COCKLE, JOHN, M.A., M.D., F.R.C.P., 7, Suffolk-place, W., and West Moulsey Lodge, Surrey, Physician to the Royal Free Hospital. VP, c 2, L 3, ‡ 5, SM, ||, O.
- 1848 COGSWELL, C., M.D., 47, York-terrace, Regent's-park, W.C. s 4, ‡ 7, 3 || (*Trustee*).
- 1867 \*COLES, GEORGE CHARLES, Esq., 20, Great Coram-street, Russell-square, W.C. ‡ 6, || 3, c 1.
- 1872 COLES, J. OAKLEY, Esq., L.D.S., R.C.S., 81, Wimpole-street, W. ‡ 2.
- 1853 COLLAMBELL, C., F.R.C.S., 15, Lambeth-terrace, Lambeth, S. ‡ 2, || 2.
- 1870 COLLIE, ALEXANDER, M.D., Resident Medical Officer to the Fever Hospital, Homerton, E.
- 1871 COOK, JOHN, M.D., 3, Upper Wimpole-street, W., Senior Physician to St. Marylebone General Dispensary, and Physician to the Out-patients, Great Northern Hospital. ‡.
- 1863 COOPER, ALFRED, F.R.C.S., 9, Henrietta-street, Cavendish-square, W., Surgeon to the West London Hospital, and to (Out-patients) Lock Hospital; Assistant-Surgeon to St. Mark's Hospital for Fistula. || 3, c 3, ‡ 5.
- 1873 COOPER, Sir HENRY, Kt., M.D., F.R.C.P., 9, Charlotte-street, Hull, Senior Physician to the Hull General Infirmary. (*Councillor*.)
- 1872 CORFIELD, W. H., M.A., M.D., 8, Bolton-row, Professor of Hygiene, &c., University College Hospital; Medical Officer for Health to St. George's, Hanover-square. || 2, ‡.
- 1851 \*COTTON, R. PAYNE, M.D., F.R.C.P. (FM 1851), 33, Cavendish-square, W., Senior Physician to the Hospital for Consumption and Diseases of the Chest, Brompton. c 3, ‡ 2.
- 1861 COULSON, WALTER J., F.R.C.S., 29, St. James's-place, S.W., Surgeon to the Lock Hospital and St. Peter's Hospital for Stone. s 2, c 3, ‡ 6.
- 1849 COULSON, WILLIAM, F.R.C.S., Hon. Fellow, q.v.
- 1874 CRAIGIE, J. H., Esq., 13, Portland-place, W. ‡.
- 1873 CRAVEN, R. MARTIN, Esq., 14, Albion-street, Hull.
- 1871 CRISP, EDWARDS, M.D., 29, Beaufort-street, Chelsea, S.W. SM FM 1872, c, § 3, ‡ 3.
- 1872 CROMBIE, JOHN M., M.A., M.B., 140, Finboro'-road, West Brompton, S.W.

*Elected*

- 1855 CROSS, R., M.D., F.R.C.P. Edin., 42, Craven-street, Strand, W.
- 1874 CUMBERBATCH, A. E., M.B., F.R.C.S., 7, Queen Anne-street, W. 2 ||.
- 1871 DALBY, WM. BARTLETT, M.B. Cantab., F.R.C.S., 8, Savile-row, W.,  
Aural Surgeon and Lecturer on Aural Surgery at St. George's  
Hospital.
- 1865 DALE, G. C., M.D., F.R.C.S., 1, Ledbury-road, W. ||.
- 1873 DALY, OWEN, M.D., F.R.C.S., 25, Albion-street, Hull.
- 1868 DANIEL, WILLIAM COLE, Esq., Stony Stratford. NS.
- 1831 DAVIDSON, THOMAS, M.D., Shaftesbury House, Bayswater, W. VP 2, c 5,  
|| 20, SM, ‡, §.
- 1868 DAVY, RICHARD, F.R.C.S., 33, Welbeck-street, W., Surgeon and Lecturer  
on Anatomy at the Westminster Hospital. ‡ 3 (*Hon. Sec.*).
- 1873 DAWES, RICHARD ST. MARK, Esq., Clare, South Australia.
- 1871 DAY, HENRY, M.D., F.R.C.P., Stafford. NS.
- 1867 DAY, WM. HENRY, M.D., 10, Manchester-square, Physician to the Sama-  
ritan Free Hospital for Women and Children. || 5, ‡ 6.
- 1871 DE RENZY, A. O. C., Esq., Lahore. NS.
- 1844 \*DIAMOND, HUGH W., M.D., Twickenham House, Twickenham, Middle-  
sex. ‡ 2.
- 1868 DICK, HENRY, M.D., 59, Wimpole-street, W., formerly Surgeon to the  
National Orthopedic Hospital.
- 1871 DICKINSON, JAMES C., Esq., 8, Chapel-place, Cavendish-square.
- 1872 DOWN, J. LANGDON, M.D., F.R.C.P., 39, Welbeck-street, W., and Nor-  
mansfield, Hampton Wick, Physician to the London Hospital. 2 ||.
- 1871 DOWSE, THOMAS S., M.D., Central London Sick Asylum, Highgate,  
N. ‡.
- 1874 DRYSDALE, C. R., M.D., 99, Southampton-row, W.C., Physician North  
London Consumption Hospital.
- 1848 DUNCAN, JAMES, M.B., 8, Henrietta-street, Covent-garden, W.C. ‡, || 4.
- 1874 DUNCAN, B. ARCEDECKNE, M.R.C.P. Edin., Gower-house, 88, Gower-  
street, W.C. ||.
- 1857 DUNN, R. W., Esq., 13, Surrey-street, Strand, W.C. ‡ 6, c 3, || 2.
- 1848 DU PASQUIER, C. F., F.R.C.S., 62, Pall Mall, Surgeon Apothecary to Her  
Majesty; Apothecary in Ordinary to Her Majesty's Household; Sur-  
geon Apothecary to H.R.H. Prince of Wales's Household, &c. ‡ 2,  
||, c 3.
- 1873 DURANTY, E. NICHOLAS, M.D., Marseilles. NS.
- 1873 DURHAM, A. E., F.R.C.S., 82, Brook-street, W., Surgeon to Guy's  
Hospital.
- 1865 EBSWORTH, ALFRED, F.R.C.S., 11, Collingham-road, South Kensington,  
and 9, Henrietta-street, Covent-garden, W.C.
- 1860 EDMUNDS, J., M.D., M.R.C.P. Lond., 6, Savile-row, W., Physician to the  
London Temperance Hospital. ‡ 6, || 2.



*Elected*

- 1868 ELLIOTT, GEO. F., M.D., Hull. ns.
- 1869 ELLIS, JAMES, M.D., Welling, S.E.
- 1872 ELLIS, JAMES, Esq., Calcutta. ns
- 1868 EVANS, WILLIAM, M.D., 1, College-terrace, Belsize-park.
- 1869 FARQUHARSON, R., M.D., 23, Brook-street, Grosvenor-square, W., Physician to the Belgrave Hospital for Children. || 3, ‡ 3 (*Councillor*).
- 1872 FAYRER, SIR JOSEPH, M.D., K.S.I., M.D., 16, Granville-place, Portman-square, W., Physician to H.R.H. the Prince of Wales. ‡ 2, || 2 (*Councillor*).
- 1847 FIELD, WM., Esq., 224, Oxford-street, W. ‡ 7, || 2.
- 1868 FLETCHER, THOMAS BELL, M.D., F.R.C.P., Senior Physician to the Birmingham General Hospital. ns.
- 1868 FOLKER, WILLIAM HENRY, F.R.C.S., Hanley, Staffordshire. ns.
- 1873 FOSS, R. W., M.D., Stockton-on-Tees, Honorary Medical Officer Stockton Surgical Hospital.
- 1869 FOSTER, BALTHAZAR W., M.D., F.R.C.P., 16, Temple-row, Birmingham. ns.
- 1872 FOTHERGILL, J. MILNER, M.D., 22, Lower Seymour-street, W., Junior Physician to the West London Hospital. || 2.
- 1873 FOX, A.W., M.B., 16, Gay-street, Bath, Physician Eastern Dispensary, Bath.
- 1868 FOX, CHARLES HENRY, M.D., Brislington-house, near Bristol. ns.
- 1868 FOX, CHARLES JAMES, Esq., M.R.C.S., L.D.S., 27, Mortimer-street, Cavendish-square, W., Dental Surgeon to Great Northern Hospital, and Dental Surgeon to Dental Hospital of London. || 5, ‡ 5.
- 1871 FOX, FRANCIS, L.R.C.P., 1, Hamilton-terrace, Ladbroke-grove, Kensington-park, W. || 2.
- 1868 FOX, JOHN M., Esq., Armaside, Cockermouth.
- 1863 FOX, TILBURY, M.D., F.R.C.P., 14, Harley-street, W., Physician to the Department for Diseases of the Skin, University College Hospital. c, ‡ 4, LL.
- 1869 FRAMPTON, THOMAS, L.R.C.P., 62, Gloucester-terrace, Hyde-park. ||.
- 1868 FREER, ALFRED, Esq., Stourbridge. ns.
- 1868 FRY, FRED., F.R.C.S., Maidstone. ns.
- 1868 GAINÉ, CHARLES, Esq., Bath. ns.
- 1862 GANT, F. J., F.R.C.S., 16, Connaught-square, W., Surgeon to the Royal Free Hospital. || 2, ‡ 5, LL, o (*Councillor*), c 2.
- 1849 GARDNER, HARRY, M.D., Westbourne-terrace-villa, Westbourne-square, W. c 2.
- 1847 GARROD, ALFRED B., M.D., F.R.C.P., F.R.S., 10, Harley-street, W. p, vp 2, c 9, o, LL, ‡ 2.
- 1849 GAY, JOHN, F.R.C.S., 10, Finsbury-place South, E.C., Senior Surgeon to the Great Northern Hospital; Consulting Surgeon to the Idiot Asylum, Earlswood, and to the Metropolitan Railway. p, LL, c 3, o, ‡ 6 (*Treasurer*), || 4.

*Elected*

- 1873 GEE, ROBERT, M.D., 5, Abercrombie-square, Liverpool.
- 1856 GIBBON, S., A.B., M.B., 11, Finsbury-place South, E.C., and 39, Oxford-terrace, W. ‡.
- 1873 GILL, JOHN B., M.D., 73, Manor-road, Folkestone.
- 1867 GILL, WILLIAM, Esq., L.R.C.P. Lond., 11, Russell-square, W.C. ‡ 2.
- 1871 GLYNN, T. R., M.B., Liverpool. NS.
- 1857 GODFREY, JOHN, M.D., F.R.C.P. Edin., Mount-terrace, E.
- 1869 GODSON, CLEMENT, M.D., 8, Upper Brook-street, Grosvenor-square, W., Physician to the Samaritan Free Hospital for Women and Children. 4 ‡, 4 || (*Councillor*).
- 1872 GODSON, CHARLES, F.R.C.S., Barnet, Herts, Medical Officer Barnet Union. 2 ||, ‡ 2. NS.
- 1853 GOLDSBRO, THOMAS W. J., M.D., 40, West-square, Southwark, S.E.
- 1869 GOODMAN, CHARLES ROWLAND, M.D., Cheetham, Manchester. NS.
- 1873 GOODSALL, D. H., F.R.C.S., 34, Finsbury-square, E.C., Surgeon to the Free Hospital. 2 ‡.
- 1874 GOWLLAND, P. Y., F.R.C.S., 34, Finsbury-square, E.C., Senior Surgeon to St. Mark's Hospital for Fistula.
- 1867 GRASEMANN, C. EDWARD, M.D., 46, Albany-street, Regent's-park, N.W. || 3.
- 1872 GRAY, ROBERT, Esq., Indian Medical Service. NS.
- 1843 \*GREENHALGH, ROBERT, M.D., 72, Grosvenor-street, W., Physician-Accoucheur and Lecturer on Midwifery and the Diseases of Women and Children, St. Bartholomew's Hospital; Consulting Physician to the City of London Lying-in and Samaritan Hospitals, &c., &c. P, VP, O, C 5, S 3, ‡ 4.
- 1868 GREGSON, GEO., Esq., 26, Harley-street, Dental Surgeon to the Dental Hospital of London and to the Metropolitan Free Hospital. ‡ 4, || 3.
- 1873 GRIEVE, ROBERT, M.D., New Amsterdam, B. Guiana.
- 1868 GRIFFITH, THOMAS TAYLOR, F.R.C.S. (Eng.), Wrexham. NS.
- 1875 GRIFFITH, G. DE GORREQUER, M.D., 9, Lupus-street, St. George's-square, S.W.
- 1874 GRIFFITH, R. GLYN, Esq.
- 1873 GRINDROD, R. B., M.D., Townsend House, Great Malvern.
- 1859 HABERSHON, S. O., M.D., F.R.C.P., 70, Brook-street, Senior Physician to, and Lecturer on the Practice of Medicine at, Guy's Hospital. P, C 3, O, ‡ 5, || 2, LL.
- 1869 HADEN, W. H., M.D., 66, Harley-street. ||, ‡.
- 1868 HAINWORTH, JOHN. F.R.C.S., 138, Camden-road, N.W. || 4 (*Councillor*), ‡.
- 1874 HALL, F. DE HAVILLAND, M.D., 6, Bedford-place, Russell-square, W.C. ‡.
- 1871 HAMILTON, ROBERT, M.D. Cantab. ||, ‡.
- 1834 HARDING, WM., Esq., 4, Percy-street, Bedford-square, W.C. VP 2, C 3, ‡ 5, ||.
- 1875 HARDWICKE, HERBERT JUNIUS, M.D., Highfield-terrace, Sheffield.

*Elected*

- 1873 HARDWICKE, JUNIUS, Consulting Surgeon, M.R.C.P., Senior Consulting Surgeon to the Rotherham Infirmary.
- 1872 HARDY, HORATIO N., F.R.C.S. Edin., Surgeon City of London and East London Dispensary. || 3.
- 1850 HARE, CHARLES J., M.D., F.R.C.P., Hon. Fellow, *q.v.*
- 1865 HARPER, PHILIP, F.R.C.S., 30, Cambridge-street, Hyde-park, W. ‡.
- 1873 HARLEY, EDWARD, L.R.C.P., Saffron Walden, Surgeon to Saffron Walden Hospital.
- 1875 HARRER, CHARLES, Esq., L.R.C.P., 34, City-road, E.C.
- 1871 HARRIS, CHARLES JAMES, Esq., 11, Kilburn Priory, N.W. || 2.
- 1872 HARRIS, HENRY, M.D., Trengweath, Redruth, Cornwall. || 2, ‡. NS.
- 1873 HARRIS, WM. JOHN, Esq., 13, Marine Parade, Worthing. || 2, ‡.
- 1851 HARRISON, C. H. ROGERS, F.R.C.S., Vine House, Stockwell-road, S., Consulting Surgeon to St. Pancras Infirmary; Honorary Surgeon to Brixton and Stockwell Dispensary. VP 2, C 3, S 5, T 6, SM, ‡ 21, || (*Trustee and Chairman of Council.*)
- 1871 HARRISON, REGINALD, F.R.C.S., Liverpool, Lecturer on Surgery at the Royal School of Medicine. NS.
- 1865 HARVEY, J. A., Esq., 35, Princes-square, Bayswater, W.
- 1847 HARVEY, WM., F.R.C.S., 2, Soho-square, W., Surgeon to the Royal Dispensary for Diseases of the Ear; Aural Surgeon Great Northern Hospital, &c. C ‡, 10, || 7.
- 1875 HASTINGS, GEORGE, Esq., St. Bartholomew's Hospital, E.C.
- 1852 HAWARD, EDWIN, M.D., 9, Harley-street, W. ‡ 3.
- 1852 HAWKSLEY, THOMAS, M.D., 6, Brook-street, Grosvenor-square, W., Consulting Physician to the Margaret-street Infirmary for Consumption. C 5, ‡ 2, ||.
- 1872 HAZEL, GEORGE, Esq., 71, Oakley-square, N.W. 2 ||, ‡.
- 1873 HEARD, R. LYNN, Esq., 5, Crawford-square, Londonderry.
- 1869 HEATON, JOHN DEAKIN, M.D., F.R.C.P., Leeds. || 4. NS.
- 1871 HEMMING, W. B., Esq., 26, Notting-hill-terrace, W., Consulting Surgeon Notting-hill and Shepherd's-bush Dispensary. ‡, || 2.
- 1853 HENRY, A., M.D., 57, Doughty-street, W.C. C 7, ‡ 4.
- 1872 HICKS, JOHN BRAXTON, M.D., F.R.C.P., F.R.S., 24, George-street, Hanover-square, Physician-Accoucheur and Lecturer on Midwifery and Diseases of Women and Children, Guy's Hospital. || 2, ‡.
- 1868 HILL, R. GARDNER, L.R.C.P., &c., Res. Phys., Earl's Court House, Old Brompton. S 2, ‡, ||.
- 1867 HILL, THOS. HARVEY, Esq., 4, Stanhope-terrace, Bayswater. ‡ 7, || 5 (*Councillor*).
- 1845 HILTON, JOHN, F.R.S., F.R.C.S., Hon. Fellow, *q.v.*
- 1840 HIRD, FRANCIS, F.R.C.S., 13, Old Burlington-street, W., Surgeon to Charing-cross Hospital. P 2, VP 6, C 12, LL, O 2, ‡ 20 (*Trustee*).
- 1873 HOBSON, W. H., Esq., Great Berkhamstead, Herts, Honorary Surgeon West Herts Infirmary.



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- 1873 HODGE, B. TERRY, L.R.C.P., Sidmouth, Devon.
- 1848 HOGG, JABEZ, Esq., 1, Bedford-square, W.C., Surgeon to the Royal Westminster Ophthalmic Hospital. vp, c 2, ‡ 9, || 2.
- 1868 HOLMAN, CONSTANTINE, M.D., Reigate. 2 ‡, 2 ||.
- 1873 HOOPER, ALFRED, F.R.C.S., 249, The Chase, Clapham-common.
- 1875 HOPE, WILLIAM, M.D., 5, Bolton-row, Mayfair, W., Senior Physician Queen Charlotte's Lying-in Hospital.
- 1865 HUME, F. H., Esq., 58, Devonshire-street, Islington, N. ‡.
- 1874 HUSBAND, H. AUBREY, M.B., Bentinck House, Stroud-green-road, Finsbury-park, N.
- 1874 HUTCHINSON, S. J., Esq., 44, Brook-street, W.
- 1833 HUTCHINSON, F., F.R.C.S., M.D., 29, Woburn-place, Russell-square, W.C. c 13, ‡ 9.
- 1869 IRWIN, W. C., Esq., Leicester. ns.
- 1868 JACKSON, J. HUGHLINGS, M.D., F.R.C.P., 3, Manchester-square, W., Physician to the London Hospital and to the Hospital for Epilepsy and Paralysis. c 2.
- 1853 JACKSON, R., M.D. (Edin.), 53, Notting-hill-square, W., Consulting Surgeon Notting-hill and Shepherd's-bush Dispensary.
- 1871 JACKSON, T. CARR, F.R.C.S., 91, Harley-street, W., Surgeon to the Great Northern Hospital, and to the National Orthopædic Hospital. || 2.
- 1875 JAGIELSKI, APOLLINARIS VICTOR, M.D. Berl., 8, Weymouth-street, Portland-place, W., Visiting Physician Infirmary for Consumption.
- 1856 JEPHSON, J. H., M.D., 20, Warwick-gardens, Kensington, W., late Physician to the Great Northern Hospital. c 2, ‡ 4.
- 1873 JOHNSON, J. S., Esq., High-street, Croydon, Surgeon to the Croydon Dispensary.
- 1873 JOHNSTON, JAS., M.B., 9, Easy-row, Birmingham, Physician to the Queen's and Children's Hospitals, Birmingham.
- 1875 JONES, SYDNEY, M.B., F.R.C.S., 10B, St. Thomas's-street, S.E., Surgeon and Lecturer on Surgery St. Thomas's Hospital.
- 1875 JONES, WALTER, M.D., 45, Finsbury-square, E.C.
- 1874 KAVANAGH, PATRICK, M.D., Lorne House, Wickham-road, Lewisham-road, S.E.
- 1874 KEENE, JAMES, F.R.C.S., 33, Maddox-street, W., Assistant-Surgeon to the Westminster and Central London Ophthalmic Hospitals. ‡.
- 1847 KELLOCK, W. BERRY, Esq., Stamford-hill, N. || 2, ‡.
- 1873 KEMPTHORNE, JOHN, F.R.C.S., Callington, Cornwall.
- 1866 KING, KELBURNE, M.D., Hull. ns.
- 1868 KIRKMAN, WM. P., M.D., Barming-heath, Maidstone. || 2, ‡. ns.
- 1860 KITCHING, JOHN, M.D., The Retreat, York. ns.
- 1868 KNAGGS, SAMUEL, Esq., Huddersfield. ‡. ns.
- 1875 KNOX, JOHN, M.D., Resident Medical Officer Bethnal House, E.

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- 1868 LAKE, W. C., M.D., Teignmouth, Devon. ‡ 2, ||. NS.
- 1875 LATTEY, JAMES, Esq., 8, Allen-terrace, Kensington, W.
- 1858 LAWSON, GEORGE, F.R.C.S., 12, Harley-street, W., Surgeon to the Royal London Ophthalmic Hospital, and Surgeon to the Middlesex Hospital. VP 2, C 3, ‡ 4.
- 1873 LAWSON, HENRY, M.D., 10, George-street, Hanover-square, Assistant Physician to St. Mary's Hospital.
- 1853 LEARED, ARTHUR, M.D., F.R.C.P., 12, Old Burlington-street, W., Senior Physician to the Great Northern Hospital. C 3, O, ‡ 5, || 2.
- 1875 LEE, SAMUEL J., Esq., 31, Chapel-street, Grosvenor-square, W.
- 1869 LEE, C. A., M.D., Surgeon, R.N. NS.
- 1852 LEE, HENRY, F.R.C.S., 9, Savile-row, W., Surgeon to St. George's Hospital. VP 2, C 4, ‡ 6, LL.
- 1873 LEE, R. J., M.A., M.D., 28, Maddox-street, W., Assistant Physician-Accoucheur to St. George's Hospital; Assistant Physician to the Hospital for Sick Children. ‡ 2.
- 1873 LEEDS, THOMAS, Esq., Wicker, Sheffield, Lecturer on Physiology Sheffield School of Medicine.
- 1858 LEMON, OLIVER, Esq., Langley-hill House, Kings Langley, Herts. ||.
- 1876 LEWIS, LOUIS, M.D., 73, Albert-street, Regent's-park, N.W.
- 1867 LICHTENBERG, GEORGE, M.D., 47, Finsbury-square, Surgeon to the German Hospital. || 3, ‡.
- 1874 LIEBREICH, RICHARD, Esq., 14, Albemarle-street, W., Ophthalmic Surgeon and Lecturer at St. Thomas's Hospital.
- 1869 LIPSCOMB, JOHN T. N., M.D., St. Albans, Herts. NS.
- 1868 LITTLETON, THOMAS, M.B. (Lond.), Plymouth. 2 ||. NS.
- 1870 LLOYD, RIDGWAY R. C. C., Esq., St. Albans. NS.
- 1873 LOE, J. S., Esq., Woodhouse-lane, Leeds. || 2, ‡.
- 1868 LOWE, JOHN, M.D. (Edin.), Kings Lynn. NS.
- 1868 LUND, EDWARD, F.R.C.S., Manchester. NS.
- 1869 LUNN, WM. JOSHUA, M.D., Hull. NS.
- 1871 MACCORMAC, WILLIAM, M.A., F.R.C.S., 13, Harley-street, W., Surgeon and Joint Lecturer on Surgery at St. Thomas's Hospital. ||, ‡. (*Councillor*.)
- 1862 MACKENZIE, MORELL, M.D., 19, Harley-street, W., Physician to the Hospital for Diseases of the Throat, and Lecturer on Diseases of the Throat at the London Hospital. ‡ 2, ||.
- 1868 MACKINDER, DRAPER, M.D., Gainsborough. NS.
- 1861 MACLAREN, A. C., Esq., 60, Harley-street, W. || 2, ‡ 3.
- 1865 MACPHERSON, J., M.A., M.D., 35, Curzon-street, Mayfair, W., Inspector-General of Hospitals, H.M. Bengal Army (Retired). || 4, ‡ 2.
- 1869 MADDEN, CHRISTOPHER, M.D., 95, Maida-vale, W.
- 1869 MAGILL, M., M.D., Royal Dockyard, Sheerness, Staff-Surgeon R.N., F.R.C.S. 2 ‡. NS.

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- 1873 MANSFIELD, PIERCE, M.D., R.N., 14, Surrey-villas, Woodland-road, Upper Norwood.
- 1868 MARSH, JOHN C. LORY, M.D., Greenhithe, Kent. ns.
- 1873 MARSHALL, EDWARD, Esq., Mitcham, Surrey, Medical Officer to the Mitcham Dispensary.
- 1869 MARSHALL, JAMES, M.D., Aberdeen. ns.
- 1844 MARSHALL, PETER, F.R.C.S., Gordon-villa, East-Cowes, Isle of Wight. P, v.p., T, c 7, ‡ 13, SM, ||.
- 1869 MARSHALL, WILLIAM, M.D., Mortlake, Surrey.
- 1865 MARSHALL, W.G., F.R.C.S., Asylum, Colney Hatch, Middlesex. || 3, ‡ 3.
- 1837 MARSON, J.F., F.R.C.S., Resident Surgeon Smallpox Hospital, N. vP 2, c 8, ‡ 7.
- 1873 MARTIN, ADAM RAE, Esq., Rochester, Surgeon to St. Bartholomew's Hospital, Rochester. ‡.
- 1868 MARTIN, WILLIAM, F.R.C.S., Oriental Club, Hanover-square, || 5.
- 1871 MARTLAND, W., Esq., Blackburn. ns.
- 1862 MASON, FRANCIS, F.R.C.S. (Exam.), 5, Brock-street, Grosvenor-square, Senior Assistant Surgeon to St. Thomas's Hospital. c 4, ‡ 6, SM, o, s 2, || 5.
- 1869 MATHEWS, ROBERT, Esq., Bickley, Kent. 2 ||. ns.
- 1873 MAUL, E. H., M.D., Southampton, Physician to the Royal Hants Infirmary.
- 1859 \*MAUNDER, C. F., F.R.C.S. 16, Queen Anne-street, Surgeon and Demonstrator of Operative Surgery, London Hospital. 2 ||, LL (*Vice-President*).
- 1871 MAURICE, OLIVER C., Esq., Reading. ns.
- 1851 MAY, W. COSTALL, Esq., 52, Tregunter-road, South Kensington, and 27, Bow-Lane, E.C., Hon. Surg. to Vintry Ward Schools, and Surgeon to the Royal Humane Society. ‡ 4, || 3.
- 1862 MAYBURY, A. K., Esq., Richmond, Surrey. ns.
- 1869 McDONAGH, JAMES A., F.R.C.S., Mornington Villa, 211, Hampstead-road, N.W. ||.
- 1869 McHARDY, MALCOLM M., Esq., 34, Stanley-street, S.W.
- 1868 McINTYRE, J., M.D., 4, Odiham, Hants. ns.
- 1865 McOSCAR, JOHN, M.D., 4, Argyll-street, Regent-street, W. ‡.
- 1866 MEREDYTH, COLOMIATI, A. W. L., M.D., 76, Margaret-street, Cavendish-square, W.C. ‡.
- 1873 MÉRIC, HENRY DE, Esq., 52, Brook-street, W.
- 1850 MÉRIC, VICTOR DE, F.R.C.S. (Exam.), 52 Brook-street, Grosvenor-square, W., Surgeon to the Royal Free Hospital, and to the German Hospital, Dalston. P, vP, c 8, LL. o, || 3, ‡ 12 (*Councillor*).
- 1873 MERRYWEATHER, HENRY, M.D., 17, Howard-street, Sheffield, Lecturer on Dental Surgery Sheffield School of Medicine.
- 1865 MIDDLEMIST, R. P., Esq., Surgeon to the Westminster General Dispensary, 10, Bedford-place, Russell-square, W.C. ‡ 3, || 3.



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- 1858 MILLAR, JOHN, Esq., Medical Superintendent, Bethlem House Asylum, N.E. ‡ 8, || 3.
- 1859 MILLER, WILLIAM, Esq., 4, Duke-street, St. James's, S.W. ‡ 4.
- 1860 \*MONTEFIORE, N., F.R.C.S., 36, Hyde-park-gardens, W. ‡ 3, || 4.
- 1875 MOORE, JOSEPH, M.D., Balham. ‡.
- 1871 MORLEY, ALEXANDER, Esq., 42, Albemarle-street, W. || 4, ‡ 3.
- 1868 MURRAY, JOHN CARRICK, M.D., Newcastle-on-Tyne. NS.
- 1868 MURRAY, J. JARDINE, F.R.C.S.E., Brighton. NS.
- 1873 MYERS, H. R., Esq. 30, Euston-square, N.W.
- 1868 NANKIVELL, CHARLES B., M.D., Torquay. NS.
- 1870 NAPIER, WILLIAM DONALD, Esq., 22, George-street, Hanover-square, W. || 5, ‡ 4 (*Councillor*).
- 1868 NEVINS, BIRKBECK J., M.D., Liverpool. ‡. NS.
- 1876 NEWHAM, JAMES, Esq., 49, Welbeck-street, W.
- 1871 NICHOLLS, JOHN F., M.D., Devizes. NS.
- 1868 NOBLE, DANIEL, M.A., M.D., F.R.C.P., Manchester. NS.
- 1869 NORRIS, WILLIAM, M.D., Stourbridge. NS.
- 1871 OGLE, WILLIAM, M.A., M.D. (Cantab), F.R.C.P. Lond., Derby. NS.
- 1873 OGSTON, ALEXANDER, M.D., 252, Union-street, Aberdeen, Professor of Medical Jurisprudence to the University of Aberdeen. NS.
- 1872 OGSTON, FRANCIS, M.D., 156, Union-street, Aberdeen, Professor of Medical Logic and Jurisprudence to the University of Aberdeen. NS.
- 1875 ORD, WILLIAM M., M.D., 7, Brook-street, W., Assistant Physician and Lecturer on Physiology, St. Thomas's Hospital.
- 1868 OSBORNE, JOHN, M.D., F.R.C.S. (Exam.), Bitterne, near Southampton. NS.
- 1873 OWEN, FRANCIS, Esq., Sunnyside, Leatherhead. ||.
- 1867 PARKINSON, GEORGE, Esq., 50, Brook-street, Grosvenor-square, W. 2 ||, ‡.
- 1871 PARSONS, F. H., M.D., Barking. 2 ||. NS.
- 1872 PATTEN, CHARLES A., Esq., Cambridge-villa, Ealing, W.
- 1854 PAUL, J. H., M.D., Camberwell House, Camberwell, S.E. c 3, ‡ 7, || 4 (*Councillor*).
- 1854 PAVY, F. W., M.D., F.R.C.P., F.R.S., 35, Grosvenor-square, W., Physician and Lecturer on Physiology, Guy's Hospital, &c. LL, c (*Vice-President*).
- 1871 PEDLER, GEORGE H., Esq., 6, Trevor-terrace, Knightsbridge, S.W. ||.
- 1869 PEMBERTON, OLIVER, F.R.C.S., Birmingham. NS.
- 1870 PENNEFATHER, JOHN. Esq., 57, Harley-street, W., Surgeon to the Metropolitan Dispensary for Diseases of the Ear. ‡ 3.
- 1868 PERCIVAL, CHARLES J., M.D., 7A, Manchester-square W. ||.
- 1873 PEREZ, DIEGO, M.D., Monte Video.
- 1871 PERRIGO, JAMES, M.D., Montreal. NS.
- 1873 PHILIPS, G. R. T., Esq., 17, Garway-street, Leinster-square, Hyde-park. ||.

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- 1869 PHILLIPSON, GEORGE H., F.R.C.P., M.A., M.D. (Cantab.), Lecturer on Medicine, University Durham, Newcastle-on-Tyne. NS.
- 1875 PHILPOT, HARVEY J., Esq., Cressington House, Peckham-rye, S.E.
- 1873 PORT, HENRY, M.D., 10, Finsbury-place, North, E.C., Assistant-Physician to the German Hospital.
- 1850 POTTS, WILLIAM, F.R.C.S., 12, North-Audley-street, W. c 3, ‡, ||.
- 1868 POWELL, JOSIAH T., M.D., 347, City-road, E.C.
- 1871 POWELL, R. DOUGLAS, M.D., F.R.C.P., 15, Henrietta-street, Cavendish-square, W., Senior Assistant-Physician to the Hospital for Consumption and Diseases of the Chest, Brompton; Lecturer on Materia Medica at, and Assistant-Physician to, the Charing-cross Hospital. c 2, || 3, ‡ 2.
- 1869 PRICE, WILLIAM PRESTON, M.D., Margate. NS.
- 1869 PRIOR, C. E., M.D., St. Peter's, Bedford. NS.
- 1873 PURCELL, F. ALBERT, M.D., 35, Welbeck-street, W.
- 1870 QUAIN, RICHARD, M.D., F.R.C.P., F.R.S., 67, Harley-street, W. Physician to the Hospital for Consumption and Diseases of the Chest, Brompton, &c. c 3, ||.
- 1869 RADFORD, THOMAS, M.D., Manchester. NS.
- 1861 RAMSKILL, J. S., M.D. Lond., 5, St. Helen's-place, Bishopsgate-street, E.C., Senior Physician to the Hospital for Paralysis and Epilepsy; Lecturer on Medicine at, and Physician to, the London Hospital. ‡.
- 1859 \*RAYNER, JOHN, M.R.C.P. Edin., M.D., Swaledale-house, Highbury-quadrant.
- 1851 READ, REGINALD, F.R.C.P. Ed., 1, Guilford-place, W.C., and 41, Jewin-street, E.C. c 2.
- 1850 REES, G. OWEN, F.R.S., M.D., 26, Albemarle-street, W., Consulting Physician to Guy's Hospital. VP 2, LL.
- 1872 REYNOLDS, J. RUSSELL, M.D., F.R.C.P., F.R.S., 38, Grosvenor-street, W., Professor of the Principles and Practice of Medicine in University College; Physician to University College. ‡ (*Councillor*).
- 1872 RICHARDS, J. P., Esq., Medical Superintendent, Female Department, County Asylum, Hanwell. ‡ 3.
- 1850 RICHARDSON, BENJAMIN W., M.A., M.D., F.R.S., F.R.C.P. (FM 1854), 12, Hinde-street, Manchester-square, W. P, VP, LL, c 5, o, ‡ 9, || 2.
- 1872 RINGER, THEOBALD, M.D., 7th, Bengal Calvalry. NS.
- 1861 RISDON, R., Esq., 7, James-street, Buckingham-gate, S.W. ‡ 6, || 2.
- 1830 ROBARTS, H. P., F.R.C.S. (Exam.), (FM 1844), 30, Keppel-street, W.C., VP 2; c 10, s 9, SM, ‡ 7, ||.
- 1874 ROBERT, FREDERICK THOMAS, M.D., B. Sc., 53, Harley-street, W., Assistant Physician and Teacher of Clinical Medicine, University College Hospital; Assistant-Physician to the Hospital for Consumption and Diseases of the Chest, Brompton. 2 ‡.

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- 1863 ROBERTS, A. T., M.D.
- 1869 ROBERTS, BRANSBY ROBERTS, Esq., Badlesmere House, Eastbourne. ‡, NS.
- 1868 ROBERTS, DAVID LLOYD, M.D., Manchester. NS.
- 1857 ROBERTS, D. W., M.D. Edin., 56, Manchester-street, Manchester-square, W.
- 1859 ROBERTS, J. H., F.R.C.S., 82, Finchley-road, St. John's Wood, N.W. || 3.
- 1873 ROBERTSON, W. H., J.P., M.D., F.R.C.P., Buxton, Derbyshire.
- 1869 RODEN, WILLIAM, M.D., Kidderminster. NS.
- 1868 ROGERS, ADAMS M., Esq., Surgeon H.M. Bombay Army. NS.
- 1869 ROGERS, C. E. H., L.R.C.P., Worksop, Notts. NS.
- 1856 ROGERS, J., M.D., 33, Dean-street, Soho, W., Surgeon to the Junior United Service Club.
- 1847 ROGERS, WM. RD., M.D., 56, Berners-street, W., Physician to the Samaritan Free Hospital for Women and Children, and to the Hospital for Women and Children, Vincent-square. VP, C 6, ‡ 5.
- 1868 ROLLESTON, GEORGE, M.D., F.R.S., Oxford. NS.
- 1869 ROOME, HENRY, M.D., Parkhurst, Isle of Wight. NS.
- 1874 ROSE, WILLIAM, F.R.C.S., 13, Old Cavendish-street.
- 1848 ROUTH, C. H. F., M.D., 52, Montagu-square, W., Physician to the Samaritan Free Hospital, &c. VP 2, S 4, C 6, ‡ 8, SM, || 5 (*President and Trustee*).
- 1867 SABBEN, JAMES THOMPSON, M.D., Edin., Northumberland House, Stoke Newington, N. ‡ 4, || 4.
- 1873 SALTER, JOHN T., Esq., 1, Thornhill-crescent, Islington, N.
- 1870 SAMS, JOHN SUTTON, Esq., Eltham-road, Lee, S.E.
- 1869 SANDWELL, ED., Esq., L.R.C.P., 10, Charles-street, Soho, W. || 4.
- 1863 SANSOM, A. E., M.D., 29, Duncan-terrace, City-road, N., Assistant-Physician to the London Hospital, and Physician to the North Eastern Hospital for Children. C, SM, S 2, ‡ 8, || 3, § (*Councillor*).
- 1873 SATCHELL, W. A., Esq., Kew, Surrey. 2 ||.
- 1873 SCOTT, WILLIAM, M.D., Waverley House, Huddersfield, ‡.
- 1873 SEDGWICK, JAMES, Esq., Boronghbridge, Yorkshire.
- 1868 SEDGWICK, LEONARD W., M.D., 2, Gloucester-terrace, Hyde-park, W. ‡ 4, C, || 2 (*Councillor*).
- 1869 SEMPLE, ROBERT H., M.D., F.R.C.P., 8, Torrington-square, W.C., Physician to the Hospital for Diseases of the Throat; Physician to the Eastern and Bloomsbury Dispensaries. ‡ 2, || 2.
- 1865 SEWILL, H. E., Esq., 6, Wimpole-street, Dental Surgeon to the West London Hospital. ‡ 3, ||.
- 1874 SHEPPARD, EDGAR, M.D., F.R.C.S., Professor of Psychological Medicine, King's College Hospital, and Resident Superintendent (Male Department), County Asylum, Colney Hatch, N. ‡.
- 1871 SHETTLÉ, C. C., M.D., Reading. ||. NS.



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- 1871 SHIPTON, W. PARKER, Esq., Buxton, Derbyshire.
- 1849 SIBSON, FRANCIS, F.R.S., M.D. Lond. and Dublin, D.C.L. Durham, F.R.C.P.  
59, Brook-street, Consulting Physician to St. Mary's Hospital. P.  
VP, 2, C 6, LL, ‡.
- 1868 SIMMS, FREDERICK, M.B., M.R.C.P., 13, Albert-mansions, Victoria-street,  
S.W. ‡, C 2, || 3.
- 1868 SIMS, MARION, M.D., Paris. NS.
- 1873 SKINNER, STEPHEN, M.B., Clevedon, Somerset, Surgeon Clevedon Dis-  
pensary.
- 1862 SLIGHT, GEO., M.D., 25, Brewer-street, Public Vaccinator St James's,  
Westminster. ‡ 2.
- 1871 SLOMAN, S. G., Farnham. NS.
- 1845 SMILES, WILLIAM, M.D., 44, Bedford-square, W.C., Surgeon to the House  
of Correction, Coldbath Fields, and House of Detention, Clerkenwell.  
VP 2, S 4, C 9, SM, ‡ 6.
- 1871 SMITH, EUSTACE, M.D., 58, George-street, Hanover-square, W., Physician  
to H.M. the King of the Belgians; Assistant-Physician to Victoria-  
park Hospital for Diseases of the Chest. ‡.
- 1873 SMITH, HEYWOOD, M.A., M.D., 2, Portugal-street, Grosvenor-square, W.,  
Physician to the Hospital for Women, and British Lying-in Hos-  
pital. 2 ||, ‡.
- 1873 SMITH, GILBART, M.A., M.D., 68, Harley-street, W., Physician to the  
Royal Hospital for Diseases of Chest and to St. Marylebone General  
Dispensary. ||, ‡ 2.
- 1848 \*SMITH, HENRY, F.R.C.S., 82, Wimpole-street, Surgeon King's College  
Hospital, and Consulting Surgeon Westminster General Dispensary.  
P, VP, C 3, O, LL, ‡ 10, || 4.  
SMITH, J. GREGORY, Esq., Honorary Fellow, q. v.
- 1872 SMITH, WALTER, Esq., 2, Stanhope-terrace, Gloucester-gate, Regent's-  
park, N.W.
- 1874 SMITH, W. ROBERT, L.R.C.P., 13, Crescent-road, Plumstead, Kent.
- 1874 SMYTH, WILLIAM, L.R.C.P., Kent County Ophthalmic Hospital, Maidstone
- 1869 SPENDER, JOHN KENT, M.D. (Lond.), Bath. FM. 1874. NS.
- 1864 SQUIRE, A. J. BALMANNO, M.B. Lond., F.L.S., 9, Weymouth-street,  
Portland-place, Surgeon to the British Hospital for Diseases of the  
Skin, Great Marlborough-street.
- 1869 STEAR, HENRY, Esq., Surgeon to the Saffron Walden Hospital, Saffron  
Walden. NS.
- 1869 STEDMAN, JAMES R., M.D., Guilford. ‡ 3. NS.
- 1848 \*STOKER, JOHN SHERWOOD, M.D., M.R.C.P., 2, Montagu-square, W.,  
Physician Western General Dispensary. C 10, S 2, ‡ 7, ||.
- 1873 STRANGE, W. HEATH, M.D., 13, Belsize-avenue, Belsize-park, Surgeon to  
St. Martin's Dispensary for Fistula.
- 1874 SUTRO, SIGISMUND, M.D., F.R.C.P., 37A, Finsbury-square, E.C., Senior  
Physician, German Hospital.

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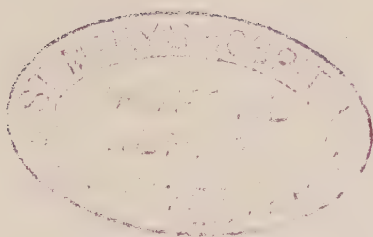
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# PROCEEDINGS

OF THE

## MEDICAL SOCIETY OF LONDON.

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*October 19th, 1874.*

VICTOR DE MÉRIC, F.R.C.S., President, in the Chair.

ON the first meeting of the session the attendance was very large, and the Fellows and Visitors were comfortably accommodated in the spacious room of the Society.

After the preliminary business the PRESIDENT briefly addressed the numerous Fellows present, and congratulated them on the resumption of their labours after the recess. He pointed out that, during the period of rest just passed, the governing body had been busy in watching over the arrangements conducing to the convenience and comfort of the Fellows. Frequent and anxious meetings had taken place to secure those ends, and to regulate everything connected with expenditure, the most scrupulous attention being paid to the interests of the Society, and care bestowed on avoiding any unnecessary liability. He was extremely glad that such a state of prosperity had been reached as to allow the publication of the 'Proceedings,' which, in a handsome volume, were now in the hands of every Fellow. The value of the further volumes depended altogether on the individual exertions of the members; their assiduity and the care bestowed on the papers and discussions would give the 'Proceedings' great merit, and raise them to the height of widely consulted works



of reference. By exhibiting pathological specimens, by reading papers on interesting subjects, by bringing forward valuable cases, and by giving to the discussions terseness and nerve, they would worthily emulate the Pathological, the Royal Medical and Chirurgical, and the Clinical Societies. The President then alluded to the lamented decease of Dr. Anstie, to whom had been confided the honorable post of Orator. He also drew attention to a past president, Mr. Peter Marshall, who, stricken by sickness, had been under the necessity of relinquishing practice and retiring into the country. A resolution was then carried, conveying to Dr. Anstie's family the deep regret the Society felt at his untimely death.

"The Medical Society of London desires to record its deep regret at the great loss it has sustained in the untimely death of its Orator, Dr. Anstie, whose valuable contributions to science (many of which were made to this Society) tended greatly to advance medical knowledge, and to place medicine and hygiene on a more satisfactory basis than heretofore. The Society directs the secretaries to convey its sincere condolences to Dr. Anstie's widow."

Dr. THEODORE WILLIAMS then related a case of

#### ULCER OF THE STOMACH PRINCIPALLY TREATED BY NUTRITIVE INJECTIONS.

A laundry woman, æt. 30, with strong hereditary history of phthisis, was admitted under his care with symptoms of hæmatemesis; the vomiting of blood, which was small in amount and clotted, being preceded by sharp pain in the left hypochondrium, nausea, and occasional vomiting of food. The hæmatemesis generally occurred between 10 and 11 a.m., had lasted for five weeks, and the patient had lost much flesh and strength. She was at first placed on liquid diet and treated by styptics and a local blister. The bleeding stopped, but the pain persisted and a distinct area of tenderness on deep pressure over the cardiac end of the stomach, most marked when that organ was empty, led to the diagnosis of ulcer of the posterior wall. All food by the mouth was then discontinued, and the patient was fed by injections of beef tea, eggs and brandy, and pills of creasote, belladonna, and, afterwards, of oxide of silver were given. Under ten days of this treatment symptoms entirely subsided, and the patient was found to have gained several pounds of flesh. She was then placed on light diet, and with the exception of a slight relapse (when a return to the injections proved equally efficacious), made a rapid recovery.

Dr. Williams then stated that the diagnosis was founded on (1) the distinctly localised pain; (2) the tenderness on pressure; (3) the time of vomiting. The frequent occurrence of ulcer of the posterior wall of the stomach was confirmed by Dr. Brinton's statistics, for he found that out of 220 cases of ulcer of the stomach, where the site was recorded, 86 were on the posterior wall, 56 on the smaller curvature, 32 on the pylorus, 10 on the anterior surface, only 13 on both anterior and posterior surfaces, thus demonstrating the far more common occurrence of ulcer of the stomach on the posterior wall than on anywhere else. He strongly urged the advantages of rest to the stomach, and drew attention to the gain in weight during the ten days the patient was subsisting entirely on nutritive injections, showing that we possess in the rectum an effective second stomach, which, if it does not afford us the pleasure of digestion, certainly spares us many of its pains.

Dr. CRISP was sceptical as to the treating of ulcers in the stomach, and mentioned that his statistics differed from those of Dr. Brinton, as the latter's included cancer, which his did not.

Dr. HABERSHON drew attention to the insidious character of phthisical disease, in which irritation of the pulmonary branches of the pneumogastric nerve led to vomiting from sympathy with the gastric branches of the same nerve. The fact of the patient being in the hospital for consumption at Brompton suggested this circumstance, and it was often found that when the irritation of the stomach subsided, the chest symptoms became more decided in character. He agreed with the diagnosis of gastric ulcer given by Dr. Theodore Williams, and regarded hæmorrhage as one of the most important indications of that disease; not, however, as a constant sign, for in that particular form alluded to by Dr. Crisp of small perforating ulcers in young and chlorotic women, it may not exist.

Ulceration of the stomach is a disease differing both in kind and degree; there may be only a small superficial ulcer like the aphthous ulcer of the mouth, which may cause hæmorrhage and very quickly and thoroughly heal, or the hæmorrhage may be produced by a chronic ulcer, either from the vascularity of its edges or from the extension of ulceration, and if the base of the ulcer be dense and fibroid and the divided vessel unable to contract, then the bleeding is often very abundant, and in many cases fatal. The ulcer may lead to this fatal result and still be extremely small, as in a specimen placed in the museum of Guy's Hospital by Mr. Hilton; in which the



ulcer, which had destroyed life by hæmorrhage, was so small, that it was only recognised after the most careful examination. As to treatment he quite agreed that rest to the affected organ was most important, and where the vomiting was severe and pain distressing, nutrient injections by the rectum were most valuable. His late colleague, Dr. Barlow, informed him of a case of his own where life was sustained by nutrient injections alone for eighty days, and the patient recovered. Patients will not, however, always submit to this plan of treatment, and bismuth with soda and small doses of morphia may then quiet irritation; for diet, milk, mutton broth, or chicken broth in small and repeated doses are better than those substances which easily undergo fermentation, as farinaceous and saccharine food. Dr. Habershon believed the case recorded by Dr. Theodore Williams to be one of great interest.

Dr. LAUDER BRUNTON considered that the successful result obtained in Dr. Williams's case showed the correctness of his method of treatment. He thought, however, that the patient might be nourished still better by employing eggs or finely pounded beef steak and arrowroot mixed with water and pancreatine, instead of beef tea and eggs alone. The eggs alone would be digested very imperfectly, whereas if they were mixed with pancreatine they would be digested very completely. The beef steak would also be digested by the pancreatine, and the arrowroot converted into sugar so as to allow of its absorption. He had tested the pancreatine made by Messrs. Savory and Moore, and found its digestive properties to be even greater than the glycerine extract of fresh pancreas prepared by Von Wittich's method.

Dr. THEODORE WILLIAMS thanked the Society for the good discussion, which, he remarked, generally endorsed his views, and drew attention to the curious feature in the case that, though many authorities regarded beef tea and white of egg as useless for nutrition, the patient gained weight on them, chemists and physiologists notwithstanding.

The PRESIDENT then read a paper on

#### RICORD AND HIS SCHOOL.

Mr. de Méric first pointed out that Hunter and Ricord had done much to dispel the confusion existing before their time, and had, in their turn, fallen into some errors. Founders of schools were not fairly judged when their systems had broken down, and he was



afraid that Ricord was now under-estimated, as he had been forced to modify the doctrines he so long and so skilfully defended. Mr. de Méric would endeavour to sketch his labours, and, in fact, the ups and downs of Ricord's school.

First, we owe to Ricord's inoculations the proof positive of the difference between gonorrhœa and syphilis, Bell having paved the way. By the same inoculations, carried on through several years and on a large scale, he put upon a reliable basis the virulent nature of chancre as a type, always limiting the inoculations to the patients themselves. Later experimenters had been bolder and inoculated healthy individuals; in this way they succeeded in showing that some of Ricord's conclusions were incorrect. He, however, clearly separated the simple from the infecting sore, and steadfastly advocated, in the face of much opposition, the use of mercury in actual syphilis. Ricord was a staunch unitist, and, though dualism is now, even by him, adopted, unitists have some reason to be obstinate in their creed. He showed by experiments certain peculiarities in the soft chancre and the manner in which the lymph-glands of the groins are affected in each variety of sore.

Ricord very justly rejects, save in hereditary syphilis, the supposition that the disease may enter the frame without primary lesion.

He battled against incubation in its wider sense and conceived not altogether wrongly, that the action of the poison remains localised for a time, and advised early destruction of the sore. Ricord had thought that all sores sprang from one root, and though wrong in this respect laid down valuable rules of treatment. Secondary symptoms were now, by his adversaries, proved contagious, and a great concession was made by Ricord; but still it remains true that the manipulations of general syphilis are less contagious than the primary.

Mr. de Méric then alluded to Mr. Morgan's and Mr. Lee's notion about the contaminating power of the vaginal secretions of syphilitic women, which power he could not allow. Ricord had done excellent service in showing the great efficacy of iodide of potassium in tertiary symptoms, and, unaided by the laryngoscope or ophthalmoscope, he had described most of the syphilitic affections of the eye and the air passages. When facts combated his theories he yielded. Mr. de Méric hoped that the imperfect sketch he had offered would serve to place in its true light the importance of the services which Ricord had rendered to science.

Mr. BRUDENELL CARTER wished to hear from the author how long, when a case of primary sore came before him, he considered the mercurial treatment should be continued with a view of preventing late symptoms. He was anxious to learn this, as he had met with cases of retinitis where the treatment had been extremely short.

Dr. DRYSDALE, whilst confessing that he was a convert to mercury for secondary symptoms, deprecated the use of this metal in tertiary manifestations.

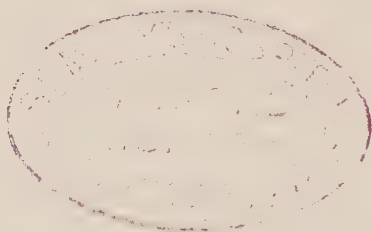
Mr. ACTON was glad Mr. de Méric had endeavoured to put Ricord's merits in their true light, and contended that the same quantity of mercury given for the infecting sore should not be administered for the subsequent symptoms, adding, however, that, to his knowledge, many tertiary symptoms did not yield to iodide of potassium.

Dr. GIBBON congratulated Dr. Drysdale on having modified his views; and

Mr. JABEZ HOGG pointed out that mercury, valuable in such an early symptom as iritis, should be withheld in retinitis, which was better controlled by iodide of potassium; he had had cases of that kind, with Dr. Brunton, where this practice had been very successful.

The PRESIDENT, in answering the different speakers, stated that short courses of mercury were not advisable; but that it is not imperative upon the surgeon to frighten his patient and at once place before him a dismal vista of years of treatment. As to tertiary symptoms he expressed his conviction that, in a certain number of cases, iodide of potassium proved powerless, and that the best results were then obtained by the use of mercury.

The Society then adjourned.



*Monday, October 26th, 1874.*

VICTOR DE MÉRIC, F.R.C.S., President, in the Chair.

MR. FRANCIS MASON exhibited a patient, æt. 19, a male, who had been under his observation five weeks with a well-marked infecting

SYPHILITIC SORE ON THE UPPER PART OF THE  
THIGH,

situated over the great trochanter. He had a secondary eruption, and no other sore in any part of the body to account for it. The patient had had connection four months past, and during the last fortnight had contracted gonorrhœa, but no primary lesion could be detected on the penis, and this case could not be explained in any other way than infection from the clothing of the female; the true nature of these cases was frequently overlooked.

MR. JOHN HAINWORTH inquired as to the length of the incubation of the poison in this case.

The PRESIDENT remarked that this was one of the numerous instances in which Mr. Mason had demonstrated that syphilitic sores were developed in the wrong place. He (Mr. de Méric) regarded the sore as the result of secondaries in the female, and resembled what was called "ulcus elevatum."

MR. DAVY said that contagion had taken place probably from a discharge saturating the sheets or the woman's night dress, thus coming in contact with the man's thigh; he asked whether primaries or secondaries existed in the female.

MR. HENRY SMITH endorsed the President's remarks, and related a case where a large glazy-looking sore on the cheek with considerable swelling existed in a married female, and had been mistaken for a tumour. Removal by operation had been recommended. On inquiry, Mr. Smith learned that the husband of the patient had a well-marked tertiary ulcer of the tongue, and had evidently inoculated his wife, who under the influence of mercurial treatment was soon cured of this so-called tumour.

MR. MASON, in reply, said that it was no business of his to find



out the period of incubation in these cases, but simply to diagnose and treat them; the date of infection could only be detected in exceptional cases, where gonorrhœa was contracted at the same time, and was followed by the appearance of sore after, it might be, six weeks.

Mr. FRANCIS MASON also showed a child aged sixteen months who had a

### CONGENITAL DEFORMITY OF THE RIGHT HAND.

It consisted of a palm of two fingers only, and these were webbed; a silk thread was passed through the proximal end of the web and allowed to remain for three weeks, when the perforation was found to be quite healed. The web was then divided, the fingers kept apart by lint, and each finger rapidly cicatrised. A cast of the hand before the operation was shown.

Mr. MAUNDER showed a case of

### EXOSTOSIS OF THE FEMUR

treated by subcutaneous fracture by means of a gas-fitter's forceps. He had broken off the bony growth which was situated in an inconvenient position, and it remained loose for some time, but no signs of its absorption appeared; latterly it had become reunited to the bone, but in a more convenient locality.

Mr. DAVY said this was a new form of practice, and as it was thoroughly subcutaneous, would expose the patient less to the dangers of pyæmia than open operation; the danger of reunion was, however, a great obstacle to its general adoption in practice.

Dr. WILTSHIRE asked whether these growths took place more frequently after puberty than before, as in his experience deformities of the pelvis and bony growths in the same region increased with age.

Mr. MAUNDER replied that his observations related to exostosis of the extremities and not of the pelvis.

Dr. MILNER FOTHERGILL then read a paper on

### THE MUTUAL RELATION OF DISEASES OF THE HEART AND THE RESPIRATORY ORGANS.

Wherever disease of the mitral valve exists, the blood pressure in the pulmonic circulation is increased. The capacity of the thorax is often diminished by attacks of congestion, and dyspnœa results.

The pulmonary vessels are thickened and dilated, and a similar condition exists in the muscular chamber of the right heart. There is often a development of connective tissue in the lungs which may possibly give strength to the lung-tissue and protect it from rupture in the violent respiration often found in mitral disease. There may be rupture of the blood-vessels, and hæmoptysis, or the formation of the "infarctus Lænnecii." The nerves of the lung are not structurally altered, but congestion produces the dry harsh cough pathognomonic of cardiac disease. The effects of venous congestion are felt in the bronchial veins, and in advanced cases there is usually bronchorrhœa. Some were inclined to regard this as due to the increased pulmonary congestion, but the clinical fact is, that the so-called bronchitis is best relieved by digitalis, which increases the blood-pressure in the pulmonic circulation. The true pathology is fulness of the bronchial vein. The pleuritic effusions of advanced heart diseases were also due to venous fulness. At other times disease of the respiratory organs induced changes in the right heart; a case recently recorded by Dr. A. Wynne Foot showed that as well as right-side hypertrophy there was enlargement of the pulmonary artery and its valves by a hyperplasia of cell elements not passing into inflammation. Valvulitis was often a hasty, well-meant, but ill-regulated growth. Commonly, disease in the lungs led to disease in the circulation, but, as Niemeyer points out, this is not the case in the diminished bulk of blood in pulmonary tuberculosis. Frequently, in acute disease of the respiratory organs, death threatens from exhaustion in the right heart. Where there is pre-existing mitral disease, attacks of bronchitis are very fatal, unless the right heart be remembered in the treatment; when so remembered, and the heart is kept up by the administration of digitalis, and other auxiliary measures are taken, attacks of bronchitis are survived by those who are already the subject of heart changes. In the treatment of both diseases of the heart and diseases of the respiratory organs, the true pathological sequence must be borne in mind, and certain consequential changes foreseen, and so guarded against, if our treatment is to be at all successful.

In the discussion which followed,

Dr. THOROWGOOD, while endorsing the author's remarks as regards digitalis, expected that venesection would have been mentioned among the remedies, for, in cases of great cardiac dyspnœa, when the vessels were turgid with blood and the right heart embarrassed, great relief was obtained by venesection. A case of thoracic



aneurism with great pressure on the pulmonic circulation had been bled in Victoria Park Hospital lately, and relief not only temporary, but permanent had been given to the patient. He considered three methods of treatment to be useful:—(1.) Free bleeding from the arm. (2.) Purgation by sulphate of magnesia. (3.) The use of digitalis. From one or other of these modes of treatment relief could be obtained.

Surgeon-Major BLACK strongly advised bleeding in these cases, and cited the instance of George IV, who, after even eighty ounces of blood had been extracted from him, was relieved by a fresh bleeding. He had found bleeding to be of no use in bronchitis after there was any amount of secretion in the bronchi.

Dr. THEODORE WILLIAMS remarked that the paper agreed to a great extent with the ordinary views of the day, and did not afford many points of discussion. Before agreeing to bleeding in these cases of pulmonary congestion from weakened circulation, he should be inclined to try every other remedial means, viz. acting by free purgation on the liver; and, above all, the use of diuretics combined with mercurials, which would often relieve the circulation so satisfactorily, that venesection was not necessary. If bleeding was to be done at all, he much preferred the use of cupping-glasses to any other mode. The author had attempted to establish an antagonism between increased connective tissue of the lung and emphysema, and had also stated that emphysema did not take place unless the lung tissue was structurally weakened. This was, however, only the case in permanent emphysema, for in the temporary emphysema of children which follows after hooping-cough or bronchitis, no structural change necessarily takes place, and the natural elasticity of the lungs enables the temporarily dilated air-cells to recover themselves.

Dr. WILTSHIRE strongly advocated bleeding, and cited a case where he had bled a man, æt. 72, suffering from great dyspnœa and turgid vessels with great relief and no danger.

Dr. EVANS had used bleeding in the first stage of cholera with good effect, and thought its disuse was more owing to timidity on the part of the practitioner as to his reputation than anything else.

Dr. ROBERT J. LEE alluded to certain cases of sudden death from so-called "fatty heart," many of which he had examined carefully post mortem, and he found no hæmorrhage into the pulmonary tissue, the existence of which Rokitansky mentioned, but generally



dry emphysema of the lung with pale bloodless tissue, or else considerable consolidation. The right side of the heart was largely dilated, the cavities being often five times the size of the left.

Dr. JOHN BRUNTON noticed that clergymen in Scotland often die suddenly in their beds, and maintained that this was due to the great stress on their circulation caused by the long extempore sermons, delivered without fresh breath being taken at the proper time, and this caused pulmonary stasis and eventual dilatation of the heart.

Dr. FOTHERGILL replied, and the meeting adjourned.

*Monday, November 2nd, 1874.*

VICTOR DE MÉRIC, F.R.C.S., President, in the Chair.

Mr. P. Y. GOWLLAND showed a specimen of a

#### RARE FORM OF POLYPUS OF THE RECTUM

taken from a female æt. 41. The woman had suffered when a child from some bleeding, but had not taken much notice of it until ten years ago, when a growth appeared which increased considerably, and gave rise to tenesmus and bleeding. Mr. Gowlland removed the tumour, which on examination proved to be of the follicular variety, common among children, but rare in adults. He exhibited drawings of this and several other polypi.

Mr. ALLINGHAM stated in reference to the present case that there were three kinds of polypi—(1) the follicular condition of epithelial growth, and usually found among children; (2) the polypus of adults which contained more fibrous element; (3) fibrous polypus resembling fibroid tumour of the uterus. He did not agree with Mr. Gowlland, that the first form was extremely rare in adults, for he remembered several cases among them, one where the patient's age was 34, but doubtless this form was most common among children.

Dr. ROUTH stated that follicular polypi were not so rare among women, whatever they may be among men.

Dr. WILTSHIRE asked if much pain accompanied these cases.

Mr. GOWLLAND, in reply, said that the follicular form of polypus

was remarkably free from pain, but in true fibrous the pain was great, and there was a strong tendency to contraction.

MR. WM. ADAMS read a paper on a case of

STRANGULATED FEMORAL HERNIA, REDUCED BY  
LARGE INJECTIONS OF OIL, AFTER STERCORA-  
CEOUS VOMITING HAD EXISTED MORE THAN  
THREE DAYS.

On Thursday evening, the 13th March, 1873, Mr. Adams was sent for by Dr. Kavanagh, of Deptford, to a case of strangulated femoral hernia in a man *æt.* 48. The hernia was on the left side, small, but well defined, and the symptoms were severe; stercoraceous vomiting had set in at 4 p.m. the day previously. All efforts to return the hernia by the taxis, aided by the warm bath, &c., had failed.

The symptoms commenced with pain in the abdomen on Tuesday, chiefly referred to the upper part and right side; he had no pain in the situation of the hernia, and therefore the patient believed that the obstruction was not in the hernia, but higher up. The hernia had existed for thirty years, varied in size, but had never been completely reduced, and he had never worn a truss.

Operation was at once recommended, but the patient obstinately refused to submit to it, principally from his conviction that the obstruction was higher up in the bowels.

On Friday, the 14th, the patient remained in the same state; stercoraceous vomiting occurring every ten minutes, and all nourishment in the form of beef tea, brandy, &c., was rejected as soon as taken. He still refused the operation. Dr. Kavanagh now resorted to a method of injecting large quantities of oil, by which he had successfully treated three other cases of intestinal obstruction accompanied with stercoraceous vomiting, but without external hernia. Each injection consisted of two quarts of olive oil, three ounces of castor oil, and three ounces of turpentine mixed together. The injection was slowly performed, and a gum-elastic tube about ten inches in length used. In the present case the injections immediately returned, and in the other cases also the injections were not retained at first, but after being repeated at intervals were retained.

On Saturday afternoon, the 15th, Mr. Adams saw the patient again with Dr. Kavanagh; the symptoms were the same, but

extreme exhaustion had set in ; abdomen tense, and tenderness on pressure, chiefly over the central and upper part, but absent at the seat of hernia. The condition of the patient appeared hopeless, but between 11 and 12 p.m. Dr. Kavanagh again resorted to the oil injections, and about 2 a.m. on Sunday morning the hernia was spontaneously reduced. About 4 a.m. the bowels were copiously relieved, and all the symptoms gradually disappeared ; beef tea and brandy were retained on the stomach, and the progress towards recovery was rapid and complete. He has worn a truss ever since, and is now in good health.

Dr. SANSOM exhibited some gelatine discs of morphia and atropine for hypodermic injection ; each disc contained  $\frac{1}{6}$  or  $\frac{1}{3}$  gr. of morphia, or  $\frac{1}{120}$  gr. of atropine, and was capable of solution in a little hot water in a spoon. He advocated their use on account of their portability and their keeping better than the hypodermic solution generally used in which fungi were apt to form.

The PRESIDENT mentioned a case which he had seen with Dr. Richardson, where an injection tube twenty inches long was used and olive oil largely thrown in.

Mr. CARR JACKSON said that the diagnosis of intestinal obstructions from fæcal accumulation and from hernia could not be too distinctly made ; he remembered a case where the patient expressed himself as “stuffed” with fæces, and an operation for hernia had been suggested ; olive oil to the extent of five flasks was thrown in through an O’Beirn’s tube, and a quantity of disintegrated fæcal matter came away ; the patient died, and the rectum was found to be stuffed with fæcal masses, and part of it perforated from the distension, giving rise to peritonitis.

Dr. J. M. FOTHERGILL asked if, previous to other means, black coffee had been given, as he had read of its use being successful in some Italian cases.

Mr. ROGERS HARRISON thought the author had confused cases of intestinal obstruction from accumulation with those of intestinal hernia, and that the patient seemed to know more about the matter than the surgeon. Was it likely that hernia existed (as mentioned in Mr. Adams’ case) for ten days, without giving rise to further general symptoms ?

Mr. NAPIER asked whether the injections were used warm or cold ?

Dr. WILTSHIRE discussed the diagnosis in this case, and stated



that the presence or absence of suppression of urine would give the key to the position of the obstruction; he was in favour of the prompt use of turpentine injections, and against their repetition as liable to produce strangury; he preferred gruel in place of oil, on account of its cheapness, and thought it was very important to make out whether ulceration was or was not present in these cases.

Mr. ROYES BELL agreed with Mr. Adams as to his diagnosis of hernia in the present instance, and related a case which came under his own charge that was confirmatory.

Mr. GOWLLAND asked what enema apparatus was used, and described one that he preferred.

Mr. J. SEBASTIAN WILKINSON said it was probably a case of strangulated hernia, where the omentum as well as the gut was involved, and this accounted for its return under the influence of injection.

Mr. MAUNDER remarked that these injections acted by dilatation of the intestine, or by inciting peristalsis. In many cases of hernia he advocated opening the abdomen above Poupart's ligament, passing the finger and thumb in, and freeing the intestine from within. This he had seen done with success in more than one case.

Mr. ADAMS, in reply, said that there was no doubt about the existence of hernia in the case he had related, as it could be felt and was accompanied by stercoraceous vomiting. It was reduced of itself. It was possible that there was some other condition like intussusception present, but the hernia fully accounted for the symptoms. Coffee was not tried; oil was used cold, and the ordinary stomach-pump with an O'Beirn's tube employed. Most of Dr. Kavanagh's cases were of obscure obstruction, but the one he had related was of hernia, and although he (Mr. Adams), had long been familiar with the use of olive oil in injection, he was not aware of its employment in such large quantities.

Mr. WILLIAM ALLINGHAM then read a paper on the

#### TREATMENT OF FISTULOUS SINUSES BY MEANS OF THE ELASTIC LIGATURE.

After a brief history of the use of ligature elastic and non-elastic and of the various instruments used to increase the power of non-elastic ligatures, Mr. Allingham expressed his opinion that in certain cases the elastic ligature possessed advantages over the knife, and said they would probably be found to be the following :

I. The operation is painless, and the subsequent suffering very slight.

II. It is bloodless.

III. There is greater rapidity in the cure.

IV. The patient need not keep his bed nor even his home.

V. Its peculiar applicability to delicate patients and those suffering from phthisis.

VI. There is usually no anæsthetic required.

VII. There is a minimum amount of suppuration.

VIII. It might be added that the ligature is often a most valuable supplement to the knife.

All these points the author enlarged upon, and detailed illustrative cases. His experience of the elastic ligature was founded on its use in upwards of fifty cases of very various character. He explained his mode of using his instrument, by means of which the operation was made very easy (a description of it is given in the 'Lancet' of August 1st, 1874), and concluded his paper by expressing his conviction, that although the elastic ligature was not likely to supersede the knife in the treatment of various kinds of sinuses, yet it might be considered as a very valuable addition to our "surgical armamentarium."

*Monday, November 9th, 1874.*

VICTOR DE MÉRIC, F.R.C.S., President, in the Chair.

Mr. HENRY SMITH exhibited a tumour removed from a girl, æt. 6½, to demonstrate the

#### DIFFICULTY OF DIAGNOSIS OF TUMOURS.

It was situated over the hip-joint, extending down the thigh, and appeared about the size of a man's fist. Three eminent surgeons had seen the patient, and two of them were of opinion that the tumour was cystic, while the third maintained that it was of solid consistency. Mr. Smith thought at first that it was cystic, but, as puncturing with a grooved needle produced no fluid, he concluded that it belonged to the fatty class, and dissected it out from the

adjoining tissues. It was adherent to the periosteum over the great trochanter, and was a well-marked instance of fibro-fatty tumour. Its history proved that it should have been removed before, and Mr. Smith had seen several cases of fatty tumour which recurred, first in the form of fibroid fatty tumour, *i. e.* with increase of fibrous element, and, lastly, in a malignant form. He wished to know the opinion of the Society as to whether fatty tumours often were followed by malignant ones.

Dr. CLEVELAND and the PRESIDENT having made some remarks,

Mr. WILLIAM ROSE stated that a microscopical examination of this tumour assigned to it a malignant character.

Dr. THEODORE WILLIAMS communicated a case of

### TRANSFUSION OF LAMB'S BLOOD IN PULMONARY CONSUMPTION,

related by the recipient, Dr. Redtel, of Röhen. The author, who had well-marked tubercular consolidation of the left lung, and ulceration of the larynx, accompanied by a certain amount of pyrexia and dysphagia, was transfused with lamb's blood by Dr. Hasse, of Nordhausen, on the 1st July, and he narrates his symptoms after the operation.

The apparatus consisted of two glass tubes, and an india-rubber pipe, filled with cold solution of carbonate of soda. By means of this, blood flowed from the lamb into the median basilic vein of the author for the space of ninety-five seconds.

The first sensations were warmth in the arm, formication, and redness of the face, and after fifty-five seconds dyspnœa commenced, which became so intense that the operation had to be discontinued at the end of ninety-five seconds.

Violent pains in the loins succeeded, which, though diminished in intensity, lasted some hours; these afterwards assumed a pulsatile character, synchronous with each arterial beat, and were assigned by the author to pressure by the distended inferior vena cava and abdominal aorta on the lumbar sympathetic.

Forty minutes after the operation a general rigor with slight cyanosis appeared, followed an hour later by a reaction and profuse perspiration, lasting for five hours; pulse 140; respirations 32.

The patient slept without drugs, though badly, on account of his cough. On the second day the urine contained a trace of albumen, and five days later the usual eruption of urticaria, accompanied by



rather high fever, appeared. This lasted two days and greatly prostrated him. On the 8th of July some improvement of appetite took place.

The result of the operation appears to have been that no change took place in the symptoms with the exception of cessation of the dysphagia. Physical examination showed a considerable diminution of the lung-consolidation.

Hasse calculated that the proximate amount of blood transfused was 100 centimètres, about  $3\frac{1}{2}$  fl. oz., and stated that he regulates the quantity by the patient's appearance and sensations, having performed the operation fifty-two times, with but one bad result. He recommends it in cases of phthisis where anæmia is a marked symptom, and especially where the disease is ushered in by extensive hæmoptysis, accompanied by slight or doubtful physical signs. The pulse is one great indication; if it be full and strong, transfusion is dangerous.

Dr. Redtel suggests the use of transfusion of lamb's blood in time of war to supply great losses of blood after severe wounds.

The author, in conclusion, states that three weeks after the operation he was gradually becoming worse, having reaped no material benefit from it.

The PRESIDENT mentioned a case that had occurred in the German Hospital—that of a patient who had lost blood largely through hæmorrhage from caries; a sheep that happened to be on the premises was connected by a simple apparatus like that used by Dr. Hasse, and blood was transfused; the patient, however, died.

Dr. AVELING thought that the objection to the instrument used by Dr. Hasse was the impossibility of measuring the quantity of blood transfused. With Dr. Aveling's instrument there was no difficulty on this score. He preferred human blood to lamb's blood, and stated that he was the first to inject lamb's blood in this country, which he did in the beginning of the present year.

Dr. RICHARDSON then read a paper on

#### CERTAIN TYPES OF DISEASE INCLUDED UNDER THE TERM PURPURA HÆMORRHAGICA.

Dr. Richardson commenced by stating that in the progress of medical science and art it had often happened that one or more distinct diseases had been discovered to exist under a single generic

term. This particularly obtained in respect to the application of the term purpura hæmorrhagica.

In the short and practical paper which followed upon this introduction Dr. Richardson defined some forms of purpuric disease, each having a distinct pathology, etiology, diagnosis, and prognosis, and each requiring a particular treatment. To the forms thus referred to he applied different names, viz.—(a) aqueous purpura, (b) saline purpura, (c) vascular purpura.

*Aqueous purpura* was so named because in it the water of the blood is in excess, and the colloidal and crystalloidal parts are relatively decreased. There is no evidence that the actual quantity of fibrin is reduced, but it is distributed through too large a volume of water. Hence the blood, imperfectly protected by its coagulable fibrine, is ready to flow from the vessels like water itself from the smallest wound; it is also ready to diffuse through vessels that may be injured by a blow, or by pressure. This type of purpura has been studied by the synthetical method, and comparisons were drawn by the author between the blood observed in these researches and the blood of the human subject under the disease in question. The origin of this type of the malady was traced to hereditary causes mainly, but it may arise from mental shock. Two cases illustrative of this origin were related, in one of which the symptoms came on after fright, in the other after sudden and intense grief.

*Saline purpura* was so named because in it the blood is not surcharged with water, but is surcharged with some saline soluble substance by which the plastic colloidal fibrin is held in undue solution in the water. The synthesis of this type of malady was also explained. The disease is not hereditary, but is induced by some error of diet or other cause that increased the solubility of the fibrine through the blood. The true scorbutic eruptions and scurvy of the old schools of physic came under this head. The author added that he had seen this type of purpura induced by the excessive use of chloral. Direct loss of blood is not common in this type of purpura, but passive exudations from vascular parts, as from the jaws, are common. With the excess of saline matter the blood, in fact, will transude through soft structures, but after it has passed from the body the fibrin will slowly separate and become pectous.

*Vascular purpura* is a type of the disease in which the blood is



not modified at all. The proportions of its water, its salts and colloids, remain the same as in health, but owing to some defect in the vessels of the minute circulation those vessels allow the blood to escape if they be subjected to any blow, or strain, or pressure. The nature of the vascular change is obscure; it may be a paralysis of vessel, but the author is rather inclined to think it due to some actual structural modification of the vessels themselves. The subjects of this type of purpura are usually young, and as a rule they present some deformity, more or less marked, of the skeleton.

The diagnosis, differential and general, of the three types of purpura was minutely described, the different characters of the eruptions being defined with special care. Particularly it was pointed out that in the vascular type of the disease the eruption was hard and prominent, because, from the fact that the blood is natural, the fibrine separates where it is thrown out and coagulates there.

There is sometimes a combination of these types of purpuric disease. Dr. Richardson related a most interesting fact of this nature in the case of a patient from whom an extremely fluid blood exuded from fine points on the surface of the body.

The paper included, finally, a review of the special modes of treatment required in each type of purpura that had previously been described. A special point was made of the best method of arresting the hæmorrhage from a wound, as after the extraction of a tooth, in instances of aqueous purpura. In six cases of this kind, to which Dr. Richardson had been summoned to stop what was found to be fatal hæmorrhage, the flow of blood had been checked by the attention paid in treatment, not less to the general than to the local measures. The general treatment consisted in sustaining the patient with food, and in administering mineral acids internally, even though the flow of blood were still imperfectly staunched. The local method consisted in applying with firm pressure a plastic styptic to the bleeding part. Caustic styptics were specially condemned. In conclusion, the value of turpentine for the treatment of the vascular variety of purpura was strongly enforced, and rules for the diet of the subjects of each type of the disease were specified.

In the discussion which followed

The PRESIDENT complimented Dr. Richardson on his useful and convenient classification of purpura, which might lead us to a better



knowledge of the causes of that symptom, and to its more scientific treatment. He had seen a well-marked purpuric eruption in a patient deeply imbued with syphilis, and wished to know in what class this instance would be included.

Dr. DALDY had seen several cases of purpura among people living in the lowlands near Lewisham, and found it was generally connected with enlarged spleen.

Dr. HARE had seen a most acute case of purpura occur in a man, *æt.* 50, living at Chelsea. At first sight the patient presented the appearance of suffering from glanders. Both face and neck were a mass of extravasated blood-patches, which spread afterwards to the body, assuming at first a symmetrical character, but eventually covering the whole body. He died in twenty days from the commencement of the disease, and a cavity was found in one lung which Dr. Hare considered had something to do with the origin of the complaint.

Dr. CLEVELAND said he had seen purpura occur in patients of all ages, in the child of a few months and in persons over eighty; the worst case he had ever witnessed was one mistaken for malignant smallpox, where blood flowed from every pore, and hæmorrhage took place in the nostrils, bowels, and stomach, soon ending fatally. Though turpentine was good in these cases, he found acetate of lead better than all; and as an instance of Dr. Richardson's third form of purpura he related a case where a large spot of extravasated blood on one of the tonsils was accompanied with aneurism of the aorta, thus showing the tendency of the vessels to degeneration and rupture.

Mr. WOODHOUSE BRAINE had seen a good instance of purpura following the use of chloral. A gentleman, *æt.* 60, had been given chloral, to induce sleep, in doses of 1 dr. the first night, 10 gr. the second, 2 scr. the third, and then  $\frac{1}{2}$  dr. for two successive nights. On the sixth day large purpuric spots appeared on the calves. On two other occasions he took the same doses of chloral with the same effects.

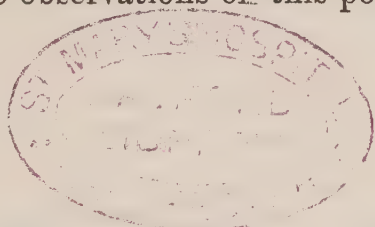
Dr. THEODORE WILLIAMS highly praised Dr. Richardson's classification, being based, as it was, on the analysis of the blood, and would prove very useful to future workers, though modification might become necessary, especially to the connection of purpura with diseases of various organs. He was surprised at no mention being made of the common occurrence of purpura with diseases of

the liver, especially in jaundice, where purpura, chiefly of the lower extremities, often made its appearance when the jaundice had lasted long ; it was by no means rare in the later stages of granular kidney ; its occurrence in malarious districts was well known, and of its following the use of chloral.

Dr. WILLIAMS gave a marked example of an asthmatic who took chloral for three days, at the rate of a scruple every three hours. The asthma ceased, but a purpuric eruption appeared affecting the lower extremities and abdomen, and lasted two days. Its disappearance was followed by a return of the asthma.

Dr. HARE remarked on the fatal prognosis which purpura in scarlet fever generally indicated. He had never known a case of scarlet fever where even one purpuric spot appeared that had not proved fatal.

Dr. SANSOM dwelt on the great difficulty of diagnosing purpura from some forms of variola, and in reply Dr. RICHARDSON stated that in his classification he had kept quite clear of variola and scarlatina, which with cases arising from marsh miasm he regarded as the result of severe blood-poisoning, forming a class by themselves ; syphilitic purpura and that arising from poisoning by chloral or mercury he would include in class two, or saline purpura, and he remarked that both fibrin and albumen had been diffused with salines and then dialysed through animal membranes. He was sorry to say that as yet he knew little about the pulse in purpura, and hoped for future observations on this point.



*Monday, November 16th, 1874.*

VICTOR DE MÉRIC, F.R.C.S., President, in the Chair.

Mr. WOODHOUSE BRAINE (through the kindness of Dr. Walter Lewis) showed one of the employés at the General Post Office, who had a large hypertrophied fold of mucous membrane on each side of the frænum, coming from the upper lip, and so large that when the lip was drawn lightly over the teeth the growth slipped from behind it, and, dropping down, entirely covered the upper teeth. The patient was about eighteen years of age, and stated that the growth

commenced about six years ago. There was no family history of any like growth.

Mr. NAPIER had noticed this peculiarity when there had been great irritation of the mucous membrane of the mouth. Certain teeth being absent, the edges of the other teeth irritated the soft parts, and this was the result.

Dr. FAYRER had seen something similar in another part of the body, in the scrotum, and he had called it nevoid elephantiasis. It had since been described by Dr. Vandyke Carter under another name, and shown to be an affection of the lymphatics of the parts.

Mr. SEWILL had seen the affection before, generally in scrofulous patients.

Mr. BRAINE also exhibited, for Dr. Cleveland, a small tumour of doubtful character, removed from a lady, æt. 74, who had always enjoyed general good health, and from her earliest recollection had had a small swelling or wart on the skin of the abdomen. About nine years ago this growth had bled a little, but did not begin to enlarge until the beginning of the present year, when, after a journey from Scotland, it grew to the size of a hazel nut, causing considerable pain and uneasiness. In the course of three or four days it presented a melanotic appearance, and when shown to Sir James Paget he believed it to be cancerous. It was removed by the knife; a digging incision was made, and the wound freely dressed with cold perchloride of iron. The patient has since done well.

The PRESIDENT had noticed, in the case of warts about the vagina and anus, that after successive removals the last growths are certainly of a malignant kind.

Mr. SEBASTIAN WILKINSON said it should be noted that the locality from which the growth was removed was often the seat of epithelioma, and that many of these so-called warts were really epithelial growths.

Dr. ROUTH remarked that as regards vaginal warts and epithelioma the microscope gave no distinctions, for under it they were identical.

Mr. W. D. NAPIER then made a communication on

#### SOMETHING NEW, OR BELIEVED TO BE SO, IN THE SCIENCE OF DENTAL SURGERY.

After a brief allusion to the encouragment afforded by the



Society towards the general advancement of science, he proceeded to treat of a case lately under his care in which he had, by an original mode of treatment, been able to perfect a new and, as he esteemed it, desirable process of operating on the mouth without causing pain to the patient, who in this instance objected to the use of anæsthesia in any shape. The case, which was illustrated by casts, was somewhat rare, the teeth in both jaws having been reduced by mercurial salivation or other cause to the condition of sharp, jagged spikes, giving great discomfort and nervous irritation. The process of filing necessary to reduce them to the level of the gum was done satisfactorily by the aid of ether locally applied during the operation until the exposure of the nerve, &c., rendered the employment of it nugatory. Then, in lieu of destroying the nerve, which is the ordinary practice under these circumstances, Mr. Napier very cautiously and gently applied to the exposed portion of it, in each tooth successively, a pencil of hickory wood dipped in nitric acid, by which simple method it was rendered insensate, and the operation necessary to enable the mouth to receive artificial substitutes was completed. Mr. Napier was anxious that the principle involved should receive a fair share of attention, as he held the present system of nerve-demolition to be at variance with true science. The paper concluded with an expression of the author's hope that the merits of a better acquaintance with dental surgery would soon be recognised by others than those whose speciality it is, and he intimated his conviction that the latter would be inestimably benefited by obtaining their education and training in duly organised schools, where alone they can obtain perfected instruction in every branch of physiology that will enable them to excel in one.

MR. SEWILL asked whether the pulps were exposed when the patient was first seen, and whether they were removed under an anæsthetic. If there was no exposure Mr. Sewill recommended the use of astringents, and if there was, he much preferred total removal of the pulp to the very painful application of actual cautery.

DR. CRISP asked whether nitric acid caused pain, and whether there was a history of syphilis.

DR. LEE, who had seen the patient, testified to his general improvement in health since his teeth had been set right.

MR. NAPIER, in reply, gave a short explanation on the points in question.

DR. R. J. LEE then read a paper on

## MATERNAL IMPRESSIONS.

Dr. Lee commenced by expressing an opinion that although the subject had often been discussed, yet the progress of scientific knowledge was a reason for considering it from time to time if it could be proved that there were sufficient grounds for modifying our views regarding it. The case related by Mauriceau of his relative who was affected during life with tremor of the hands, in consequence of the fright his mother sustained previously to his birth from the sudden loss of her husband (who was stabbed by a servant), was taken as an example of a certain class of cases of this kind. The value of a system of classification of abnormalities in the foetus according to anatomical details was shown to be useful in establishing the view that such abnormalities follow certain physiological laws, but that this system does not attempt to explain their cause. The necessity of defining what we mean by a maternal impression was pointed out as the first step towards explaining the manner in which an impression can affect the child. There appeared to be certain effects which followed purely emotional disturbances, and others which were the consequences of impressions produced by objects of fear or disgust, while between purely emotional and objective impressions there were a great variety, which affected the emotions and the senses simultaneously. Experience proved that first and last of these classes of impressions were more commonly stated to be causes of various abnormal conditions in the child, but that such effects were exhibited in some deficiency of its intellectual and moral nature, rather than in deformity or abnormality in special organs or parts of its body. In illustration of the truth of this view a few cases were selected, and Dr. Lee concluded by recommending it to the attention of the members of the Society as of greater importance than that which attempts to connect particular kinds of deformity with the object which was stated to have produced "an impression" on the mother.

THE PRESIDENT stated that Dr. Lee had extended the area of discussion by including maternal impressions on the "mind of the infant" as well as on its body.

Dr. BRUNTON did not believe in maternal impressions on the child "in utero," for omission was made in most of these instances of the negative cases, when the mother for some reason or other expected a deformity in the child which did not appear at birth ; and

again, remarkable deformities occurred without any pre-existing impression on the mind or body of the mother. He assigned those phenomena to variations in the formative power of the ovum, either defective, as where some members were absent, or excessive, as where too great development had taken place, even extending, as in the case of the Siamese twins, to two whole bodies.

Dr. SUTHERLAND could not help citing the well-known West Riding case of the goose-girl, who had certain peculiarities in the form of her jaw, neck, and scapulæ, somewhat resembling a goose; she made even a cackling sound. Before her birth, her mother had been frightened by a swan.

Dr. FOTHERGILL related some curious instances of maternal impressions taken chiefly from the lower animals, and also referred to the persistency of paternal influence.

Dr. CRISP said he had some belief in the effect of mental impressions in these cases, though originally he was much opposed to the idea.

The PRESIDENT remarked that the subjects of discussion had been much wider than those originally proposed, and he was afraid that "paternal" impressions had been mixed with "maternal."

Dr. LEE replied, and the meeting adjourned.

*Monday, November 23rd, 1874.*

Dr. BROADBENT, Vice-President, in the Chair.

Dr. THOROWGOOD read a paper on

### GASTRIC VERTIGO.

Notes of two cases as illustrating the following remarks were given.

CASE 1 was that of a gentleman, æt. 45, regular and careful in his habits of life, and by no means addicted to stimulants. This patient was troubled by frequent attacks of giddiness and vertigo; at times he would fall in a faint with transient loss of consciousness. Frequent and careful examination failed to detect any organic lesion. The face was pale, pulse slow and regular. A course of Vichy water disagreed notably in this case, and various tonics, such



as iron, quinine, &c., failed to exercise any curative action over the syncopal attacks. Wine was recommended at meals, and brandy and water whenever the attack of vertigo threatened. This treatment was regularly carried out, and the patient became decidedly worse under it. As a part of complete change in the plan alcohol was entirely abandoned, and by degrees the attacks of vertigo and syncope ceased.

CASE 2.—A lady, æt. 35, had frequent attacks of faintness in the morning on awaking, and at other times. No organic lesion could be discovered. The use of alcohol always gave temporary relief, but by degrees the attacks became so frequent that the patient was alarmed at the constant necessity for the stimulant remedy. Iron, quinine, and a variety of tonics did very little good here, but a resolute adherence to claret and water to the exclusion of other alcohols as a drink had an obviously beneficial effect. Dr. Thorowgood believed local cerebral anæmia to be the pathological condition in these cases. In certain parts of the brain the arteries were spasmodically contracted, while the venous radicles were full and engorged. It might be said that a bloodless brain was commonly assumed as the condition in a person given to fainting, and that the proper treatment was to stimulate the heart, and so send more blood to the brain. Against this idea it was urged that practical experience showed that stimulating the heart, while it relieved for a time, tended in the end to perpetuate the original malady. The true pathology might probably be found in the observations of Dr. Fothergill on cerebral anæmia in the 'West Riding Asylum Reports,' wherein were given the experiments of Cyon and Alladoff showing the inhibitory influence of certain nerves over the vessels of the brain in causing their contraction, and limited anæmia as a result. These inhibitory nerves had been traced from the liver up the vertebral arteries to the brain. Irritation of stomach and liver, thus propagated to the brain, caused spasmodic contraction of arteries, and local cerebral anæmia with all its recognised consequences. Alcohol, by tending to irritate the liver, would therefore, be injurious. The cure of these cases, even when very inveterate, might confidently be looked for in, first of all things, careful regulation of the supply of alcohol, coupled with moderation as to diet, regular exercise, and so forth. As medicines, calumba, with bicarbonate of soda and tincture of ginger, would be found very useful, the alkali tending to correct any acidity about the juices

of the stomach induced by alcohol being taken when the stomach was empty. Such acrid secretion would cause a feeling of faintness and a not unnatural craving for a little brandy. The ginger in a small dose would act as a stimulant mildly, and so relieve the craving for brandy or sherry. Subsequently the use of iron, in combination with sulphate of magnesia or soda, was to be recommended as a tonic laxation. By this simple method, carried out with decision, it was not too much to say that cases that had been called incipient epilepsy, or instances of very obscure nervous disease, might readily be cured.

Dr. FOTHERGILL was flattered at the allusion made to his essay in the 'West Riding Reports,' and remarked that a clear connection had been made out between the stomach and the larger nerve-centres through branches of the sympathetic, the occipital lobes being the portions of the brain implicated. Anæmia of the brain was not always accompanied by depression of spirits, and in these cases the state of the vessels of the brain was more probably that of spasm than of anything else. He could not help alluding to Dr. Ferrier's experiments on monkeys, where irritation of the occipital lobes produced marked symptoms of melancholia.

Dr. THEODORE WILLIAMS had seen many cases similar to those narrated by Dr. Thorowgood, and while agreeing with the treatment he could not altogether endorse the pathology. Most of these cases occurred among people with tippling habits, whose practice it was to take stimulants between meals whenever they felt what they call "low." The result was bad in two ways:—(1) The alcohol introduced into the stomach caused a large secretion of gastric juice which, having no food to act on, irritated the mucous membrane and gave rise to flatulence, distending the stomach and thereby disordering the heart's movements; hence, palpitation and irregular supply of blood to the brain with its accompanying symptoms. (2) The waste of gastric juice prevented a proper amount being forthcoming at meals, the food was only partially digested and escaped assimilation; hence, starvation of the blood and consequent anæmic symptoms. The treatment most successful, therefore, in these cases was a careful combination of food with stimulants and a reduction of the latter as much as possible.

Dr. ROUTH agreed with the author as to the common occurrence of these cases among women, often accompanied by leucorrhœa. Chronic alcoholism he noticed chiefly among matrons, and he



treated it by two methods: the hankering after stimulants he satisfied by a harmless one in the form of assafoetida or valerian, or else he gave raw-beef juice prepared by rubbing beef through a sieve and flavouring it with a little celery; three claret glasses a day were given of this juice, and it allayed the hankering for spirits without causing tapeworm. He cited a remarkable instance of recovery from its use.

Dr. BROADBENT was not sure these cases came under the head of vertigo at all. He noticed vertigo to exist in two opposite states of the vascular system—(1) with the arteries quite relaxed, skin moist, and the pulse soft; (2) with the arteries tight and the pulse strong and firm. He endorsed the author's treatment.

Dr. THOROWGOOD, replying, said that all his cases were not those of habitual tipplers, and that he had used the term vertigo for want of a better.

Dr. LEONARD SEDGWICK read the records of a case of

### RUPTURE OF MUSCLES AND PULMONARY EXTRAVASATION.

After a railway collision a gentleman, æt. 66, who was much shaken, and who was cut over the eyebrow, was seized on the third day after with severe sickening pain in the left calf, where there was a tender depression and some ecchymosis, as well as a yellow branched line in the site of the inner saphena vein. On the twelfth day he had an isolated patch of lung outside the lower angle of the scapula, where the breathing was tubular, the percussion dull, and over which there was some friction-sound. The pleuritic pain was relieved by leeches, but a few hours after a sudden pain struck him in the lower part of the right chest, like that in the calf, and there was over the base and a little below the lower ribs a harsh, grating noise, audible at a distance, produced apparently by irregular and severe contraction of dorsal muscles, coincident with each respiratory murmur, and caused, as the author believes, by rupture of muscular fibre. At a later period of the case the right calf of the leg was affected in the same way as the left had been. The agonizing pain in the back was speedily relieved by injection of morphia, and simultaneously the harsh bruit ceased.

Dr. Sedgwick was of opinion that the pulmonary extravasation was shown by the expectoration of blood-clot, and was caused by



the arrest in the lung of a small piece of clot which had been broken off from that in the leg.

After some remarks by Drs. CROMBIE and BROADBENT, Dr. T. S. DOWSE brought forward the clinical history and pathological appearances of a case which to him seemed obscure, both in its etiology and diagnosis. The patient was *æt.* 31. The special features were allied to a cerebro-spinal meningitis, anæmic poisoning, typhoid poisoning, or to some other morbid factor; but the signs and symptoms throughout the course of the diseased state were not absolutely relevant to either of the foregoing conditions. There was more or less somnolence, with twitching of bilateral groups of facial muscles, pseudo-paraplegia of the lower extremities, with cutaneous anæsthesia and muscular hyperæsthesia. There was persistent diarrhœa with involuntary discharge; no vomiting; the most marked feature being the moist, clean, healthy-looking tongue, which remained until within a couple of days of her death. The ratio of pulse, respiration, and temperature, was fully detailed. At the post-mortem there was diffuse arachnoid change over the cerebral hemispheres, with an increase of fluid in the sac. The pia mater was hypervascular. These conditions existed also in the membranes of the spinal cord, which seemed softened in the dorso-lumbar region. The lungs were healthy. There was recent adhesion between the layers of the pericardium, and attached to the anterior cusp of the mitral was an organised mass of laminated fibrin the size of a small walnut; the other cusp was quite healthy. The cavities of the heart were otherwise free from blood or ante-mortem polypoid clot. On account of this growth there could not have been complete closure of the valves, which gave rise during life to a pure and definite diastolic murmur. This Dr. Dowse thought exceptional and differing altogether from the presystolic grind of a stenosed orifice on the one hand, and the systolic regurgitant bruit on the other.

Dr. BROADBENT thought it was an instance of ulcerative endocarditis. Slight ulceration of a portion of the mitral valve had occurred in which a clot of blood formed which was fibrinous; minute portions of this had become detached and were carried into the capillaries of various organs, causing small embolism and giving rise to the pain in the spleen, the symptoms of paralysis, &c. In these cases the embolisms were very minute and not visible to the naked eye, but could be detected under the microscope. He

remembered a case where large thrombi were found in both radial and femoral arteries. As a rule, cases of capillary embolism were accompanied by minute petechiæ of the skin.

Dr. THEODORE WILLIAMS had some doubt about the blood-poisoning in this case, and, while concurring with Dr. Broadbent that it was a case of ulcerative endocarditis, drew attention to the fact that no emboli were found in the liver or lungs—the most common seat of this occurrence.

Dr. DOWSE, replying, said no emboli were found in the brain or spinal cord.

*November 30th, 1874.*

VICTOR DE MÉRIC, F.R.C.S., President, in the Chair.

Mr. J. ASTLEY BLOXAM exhibited a boy, æt. 10, having a

#### DISLOCATION OF THE PATELLA

which had existed five years. There was no pain, only a slight feeling of weakness. The dislocation occurred every time the knee was flexed, reduction taking place with extension; this, Mr. Bloxam remarked, was the contrary to what is said in books on the subject. The patient's family was generally affected with rickets.

The PRESIDENT stated that he had seen this patient at the Royal Free Hospital once, but he had not been able to make up his mind with reference to the line of treatment to be adopted. He should like to have the matter fully discussed by the Fellows.

Mr. WM. ADAMS considered the case rare and interesting, being one of dislocation of the patella accompanied with only slight knock-knee, the lesion being generally associated with a marked degree of knock-knee. Dislocation of the patella seldom caused synovitis among children, because it was a slow process, and the result, not of an accident, but of a loose condition of the ligaments and the surrounding tissues. He remembered an instance of a young gentleman who had both patellæ dislocated, and was thus rendered lame. Mr. Adams recommended the knees to be kept extended in leather splints for one or two years, and the patient entirely recovered the use of his limbs, and was able to do without any appliance.

Mr. DAVY said he knew no cases so difficult to manage as these, and related the case of a man, æt. 40, on whom a splint was used for a whole year, and on its removal the deformity returned as badly as ever. Mr. Adams' mode of treatment was far more successful in the case of children than in adults. At the Surgical Aid Society a laced knee-cap was generally made use of, though Mr. Davy considered that some mode of appliance by which the action of opposing muscles could be equally balanced was highly desirable.

Mr. BLOXAM also exhibited a patient, a woman, from whom he had removed the zygoma and styloid process in the

### EXTIRPATION OF A CYSTIC SARCOMA.

Nine years previously Mr. Hulke had excised half the lower jaw for the same disease. During the operation Mr. Bloxam had to tie the external carotid artery and the internal jugular vein, both of which were divided. He pointed out the peculiarity of the growth's returning after such a lapse of time.

The PRESIDENT said the case exemplified the wonderful depth to which operations about the jaw might be carried. He recollected a case where the basilar process was reached. In the case brought forward by Mr. Bloxam he was surprised that no septicæmia had taken place.

Mr. LEIBRIECH remarked that the want of occlusion of the eye observable in this case was due to two causes:—(1) The destruction of the seventh nerve and the orbicularis muscle; the eye could only be protected by turning it upwards. (2) The destruction of the fifth nerve, causing loss of sensation of the conjunctiva followed by corneitis and ulceration. There was no doubt that cataract had formed; he considered that the eye should be completely closed by stitches, forming an artificial symblepharon as a means to prevent further destructive changes.

Mr. BLOXAM said cataract had formed, and extensive paralysis of the fifth and seventh nerves had taken place since the last operation.

Mr. HENRY SMITH then showed a specimen of

### EXCISION OF THE KNEE-JOINT,

remarkable for the fact that when first admitted the patient seemed to have little or nothing the matter with him. After a while he complained of great pain and starting of the limb, and Mr. Smith



diagnosed ulceration of the cartilages of the knee-joint, operated, and obtained a very favorable result. His experience was against operating where the synovial membranes were extensively diseased, but only in cases where the cartilages and bone of the joint were but partially affected and no constitutional symptoms present.

Mr. RICHARD DAVY related seven cases of

### EXCISION OF THE KNEE-JOINT,

operated on by him in the Westminster Hospital (see p. 33).

In Cases 4 and 7 sinuses yet existed. Necessarily shortening of the limb occurred in every case, but all the patients can walk with the aid of a high-heeled boot, and the improvement in health and the reduction in deformity have been marked. The average stay in hospital has been 82 days, contrasting favorably with 208 days' stay of other excision-cases (*vide* 'Holmes's Surgery,' vol. iii, p. 822). The author found Esmarch's bandage a great boon in these operations. The transverse incision over the line of articulation was strongly enforced, the ends of the femur and tibia projecting (on forced flexion) like the muzzle of a double-barrelled gun. Especial care was given to the posterior ligament of the knee-joint, as it acts as a hinge to the two bones. The author slices off the ends of the bones until accuracy of adaptation results in a straight line. Sutures of stout silver-wire were used, restrained by large shot or lead-tubes. No dressings whatever are requisite, but the surgeon should brush the wound over with weak solution of Condry's fluid or carbolic acid, and attend to the temperature of the ward and enforce surrounding cleanliness. The cases were illustrated by four of the children who were present, also by casts, splints, splintage, instruments, &c., and the bones removed at the operation. Mr. Davy attributed the success which had resulted to Esmarch's bloodless plan as adopted at the Westminster Hospital, to the simplicity of the after-treatment, and to the stern enforcement of maintained rest.

The PRESIDENT, after alluding to the elaborate way in which Mr. Davy had worked out his cases, remarked that great confusion existed in the use of the terms excision and resection, and thus the difference between Mr. Holmes' and Mr. Davy's statistics might be explained. The term excision should only be applied when all the articular surfaces are carefully removed, and this was generally done only where grave disease of the joint existed. Many of Mr.

*Resections of Knee-Joints. Westminster Hospital. Mr. Richard Davy.*

No.	Sex.	Age.	Admission.	Year.	Day of operation.	Discharged.	Complaint.	Nature of operation.	Days in hosp.	Days after oper.	Result.
1	Boy	13	May 23	1871	May 30	Aug. 15	Disease of right knee. Genu valgum	Excision of internal condyle of femur	84	77	Ankylosis. Fibrous.
2	Girl	2	April 15	1872	May 14	July 2	Ankylosis. Deformity. Left	Excision of bony wedge	78	48	Osseous.
3	Girl	15	Feb. 24	1873	March 4	July 23	Ditto. Right	Ditto	149	110	Ditto.
4	Boy	8	July 21	1873	July 28	Oct. 18	Suppuration of right knee. joint	Excision of right knee-joint	89	82	Ditto.
5	Boy	4	Jan. 1	1874	Jan. 13	April 29	Ditto	Ditto	119	115	Ditto.
6	Boy	3	Mar. 2	1874	March 24	May 27	Fibrous ankylosis. Right	Ditto	86	64	Ditto.
7	Boy	8	May 16	1874	May 19	Aug. 5	Ankylosis. Deformity after resection. Left	Excision of previously excised left knee-joint	81	78	Ditto.

Davy's operations were performed on cases of more or less deformity of the joint without serious disease.

Mr. BLOXAM alluded to the absence of death in Mr. Davy's cases, and called to mind seventeen instances of excision, many of which resulted fatally; in some the operation was insufficient, and amputation had to be performed at a later date. It was not fair to compare these cases of joint-deformity where the symptoms were quiescent with the usual run of hospital cases for which excision was performed.

Mr. HOLTHOUSE bore witness to the great skill of Mr. Davy as an operator, but thought with the preceding speaker that no comparison could be made between Mr. Holmes' and Mr. Davy's statistics. He disapproved of the after-treatment, especially the non-usage of dressings, as the entire absence of cleanliness and the presence of heat and damp furnished all the elements of putridity and surrounded the patient and the other sufferers with a most unhygienic atmosphere.

Mr. DAVY agreed that his were favorable cases, but thought that they were of a character to demonstrate that the operation might be safely extended in practice. Mr. Holthouse's argument pointed, not to a discontinuance of his mode of treating wounds, but to greater care being exercised by the nurses and attendants in its application.

*Monday, December 7th, 1874.*

Dr. SANSOM, Vice-President, in the Chair.

Mr. ROYES BELL showed for Mr. Henry Smith a boy, born with a harelip and cleft soft and hard palate, who had been operated on according to Sir William Fergusson's plan with considerable success.

Mr. WILLIAM ALLINGHAM exhibited a

### SCIRRHOUS TUMOUR OF THE BREAST

removed from a woman, æt. 64, by the elastic ligature. Needles had been introduced and the ligature applied without pain and without anæsthetics. The process took seventeen days, was unaccompanied



by any rise of temperature or other unfavorable symptoms, and the patient made a complete recovery.

Mr. NAPIER inquired what kind of india rubber was used.

Mr. THOMAS BRYANT condemned the use of the ligature in ordinary surgical practice, though in exceptional cases, as when the patient was hæmorrhagic, he did not object to it. The operation was tedious, lasting in this case seventeen days, when removal by the knife would have taken seventeen seconds; besides, it had the disadvantage of retaining a mass of almost putrid matter in close connection with the body, giving rise to the danger of septicæmia. It was true the patients did not complain of severe pain, but they underwent a considerable amount of chronic suffering.

Mr. CARTER asked why ether was not used. He was under the impression that its use was unattended with risk and that no deaths had occurred from this cause.

Dr. THEODORE WILLIAMS was surprised at Mr. Carter's question. A reference to the report of the Committee of the Medical and Chirurgical Society on chloroform and anæsthetics would show him that there had been several deaths from ether, and during the experiments on animals several dogs were killed by ether as well as by chloroform, it being only a matter of dose to effect this result.

Dr. SANSOM said deaths from ether had been recorded by Trousseau and other authorities.

Mr. ALLINGHAM, in reply, said that the patient, being of a very delicate constitution, was unfitted for operation by the knife. White India rubber was used, and, the wound being freely dressed with carbolised oil and other antiseptics, no putridity existed. He knew a medical man who had been operated on by both methods, knife and ligature, and the patient greatly preferred the latter as being without pain.

Dr. ROUTH then read a paper on an

#### EPIDEMIC OF INFECTIOUS SORE THROAT

which occurred in a public institution, and the probable causes of its production. After a proper tribute to Dr. Farquharson, who had preceded him last session on a subject analogous to the present, the author first gave a description of the institution and its sanatory appliances, where every means had been taken to secure ventilation and a good supply of water and food, and also the unexceptionable cleanliness of the girls who were the inmates. Effective means were

likewise always at hand in case of infectious disorders arising, and great care taken to prevent as far as possible their introduction. One case of typhoid fever occurred in October, 1873. The patient was removed to Middlesex Hospital and ultimately died there; this was after the return of the inmates from the seaside. On the introduction of a new matron a little while after, the sore-throat disease broke out synchronously with measles and erysipelas. The appearance of measles was explained by the inmates occupying seats in an ill-ventilated church where a school, then seriously affected with this epidemic, had been sitting in the morning. One of the erysipelas-cases was subject to the disease, but all the others occurred when the throat-epidemic was at its height; one died suddenly with symptoms of sickness and exhaustion. The sore-throat epidemic (of which there were forty-six cases) exhibited three types — *simple cynanche*, *diphtheritic patches*, and *scarlet fever*. When Dr. Routh left London in September all the sanatory appliances were reported, on inspection, to be in good order. The scarlet-fever cases occurred when in the charge of Mr. Cheyne. Then on inspection again being made, the water was found impure, and the filter, having been meddled with, was no longer effective; the drains in the garden were said to be offensive. One fact was noted—of the six matrons, it was the one who drank water only, who was affected with severe cynanche. Of the six monitors all escaped except one, and she also was a water-drinker. Dr. Routh then proceeded to show that other sources of infection had not been disregarded—(1) from visitors, (2) from infection at the seaside. But on full inquiry made no such infection could be traced. He concluded by urging for discussion—1st. Were the three diseases of the throat co-existent but different affections, or the same disease? 2ndly. Was the erysipelas produced by a similar miasm? 3rdly. Can the sewage-tainted water have produced the disease, notably the scarlet fever? 4thly. Had the typhoid-fever poison—then prevailing in London—any influence.

Dr. DE HAVILAND HALL was sure that bad sewage might give rise to various forms of disease, and cited an instance where peritonitis and erysipelas arose from an escape of sewer-gas in a public institution.

Dr. FARQUHARSON was of opinion that the first class of Dr. Routh's cases had nothing to do with the last class and were quite distinct.



Mr. BRUDENELL CARTER thought the paper admirably demonstrated the perils of water-drinking. He always told his teetotal friends that until they could guarantee to society a pure specimen of the commodity they so highly prized, instead of the present often dangerous mixture, they had better cease preaching the gospel of water.

Dr. CRISP, as a water-drinker, replied that human life was curtailed at least ten years by the use of alcohol. As illustrating the connection between diphtheria and sewage, he gave an instance of a house in Devonshire where nine children died within a month from a species of diphtheria, quite unknown in the neighbourhood. On investigation the drainage of the house was found to pass into a pond, the water of which the children drank.

Mr. CHEYNE had charge of Dr. Routh's cases in his absence, and distinguished three forms of disease—(1) a pure scarlatinal case; (2) cases of sore throat devoid of rash or high temperature; (3) cases of erysipelatous sore throat. The drinking-water was the only cause of disease which could be demonstrated, as no proof of contagion existed.

Dr. BUCHANAN, in support of Mr. Carter, asked Dr. Crisp if he ever knew of nine children dying of alcohol in one house, as occurred in the melancholy instance in Devonshire? He set a high value on Dr. Routh's careful and elaborate paper, and noticed that the gap of fourteen days which intervened between the first and second batches of cases precluded any idea of infection; he had no doubt that both scarlatina and diphtheria had appeared in the Home, and that they prevailed together he was certain. Some of the cases had evidently nothing to do with either of these diseases, but must be classed with the erysipelas which appeared on the scene. He thought that a form of sore throat of the same character as the well-known hospital sore throat, but non-specific in kind, might and did arise from septic causes such as the presence of putrid matter. As for the exact source of this epidemic, it appears to be traceable to sewage, the institution being flooded with sewer-exhalations, and instead of the ventilation described purifying the air it probably assisted in freely diffusing the sewer-gas through the building. There being two methods of infection in this instance, the water and the air, it was difficult to distinguish which was the agent, but that erysipelas might arise from septic matter dissolved in water ample evidence existed. In the epidemic outbreak at the Patriotic



Asylum last autumn erysipelas came on followed by a curious form of peritonitis, which the late Dr. Anstie thought he traced to water-poison.

Dr. THEODORE WILLIAMS inquired the amount of cubic space allowed per head in the building, and whether natural ventilation was relied on, as if it were, there was little chance of keeping a crowded institution pure and wholesome. He had no doubt of the existence of sore throat, non-specific in character and arising from septic causes, and had noticed instances of it occurring chiefly among servants who occupied the basement of houses and therefore were in closer proximity to the drains.

Dr. ROUTH, in reply, said that both the beginning and the ending of the epidemic were characterised by erysipelas, and that notwithstanding all that had been said, and he was much obliged to the Society for discussing the matter so thoroughly, he saw no case made out for attributing the disease to anything else than poisoned water. In conclusion, the treatment consisted of effervescing salines, gargles containing chlorate of potash, and the local use of tannin.

*Monday, December 14th, 1874.*

F. J. GANT, F.R.C.S., Vice-President, in the Chair.

Mr. WILLIAM ROSE brought forward a case of

#### CLEFT PALATE

on which he had operated successfully. The patient, a young man, æt. 23, came under his charge about three months ago. He had a fissure extending through the soft and hard palates to within half an inch of the alveolar ridge. He spoke of the development of the upper jaws and palate, which he illustrated by diagrams, and suggested a plan of bringing the maxillæ together immediately after birth in cases of very wide cleft. He described minutely Sir William Fergusson's new method of operating for simultaneous closure of fissure in the hard and soft palates (a drawing of which was shown), by boring holes through the margin of the hard palate

for the passage of the threads, and then cutting through it with a chisel in a line parallel to and about half an inch from the edge of the cleft. By this means the edges of the cleft in the hard palate could be approximated. After dividing the levator palati muscle on each side, and carefully paring the edges, stitches could be passed through the holes in the hard and through the soft palate, and the edges brought into apposition in the median line. He demonstrated a new way of passing the threads. He spoke of Sir William Fergusson's introduction of myotomy thirty years ago, in the treatment of fissure of the soft palate, as having quite revolutionised staphyloraphy, and expressed his firm belief that the recent introduction of osteotomy in the treatment of fissures of the hard, by Sir William Fergusson, would rank high as an operation among the numerous contributions to practical surgery of that eminent surgeon. He also states that Sir William Fergusson, when he published a paper on the subject last April in the 'British Medical Journal,' was not aware that any other surgeon had suggested such a course of procedure. It was, however, shown that Dieffenbach, in his 'Operative Surgery,' published in 1845, had proposed a somewhat similar operation, but there was no evidence to show that he had ever performed it on the living subject, and his successor, Baron Von Langenbeck, had never adopted the suggestion. He added that Sir William Fergusson had operated on more than forty cases by this new method of dividing the bone, and that in all the palate was improved, and that two thirds of the cases were successful.

Mr. HENRY SMITH said that thirty years ago he had written out Sir Wm. Fergusson's original paper in which staphyloraphy was mentioned, and had also assisted in most of that eminent surgeon's operations since; in the early ones operation on the soft palate alone was attempted, and the results were not so favorable as under the new plan of osteotomy. Our transatlantic brethren thought so little of staphyloraphy that they divided the united soft palate afresh and applied obturators. Mr. Smith considered that the natural coverings were far superior to artificial ones, and thought Mr. Rose's case was thoroughly successful, the fissures in the hard and soft palates being completely closed, which was a better result than had been achieved in his case exhibited at the last meeting of the Society. Surgeons who proposed operation in these cases must be prepared for severe hæmorrhage on account of the vascularity of



the palate ; this might be stopped by ice and other means, neither had it ever been known to be fatal. He dwelt at some length on the advantages of the gag, which enabled surgeons to undertake operations that had been almost impossible before.

Mr. OAKLEY COLES stated that it was the surgeons of America, and not the dental surgeons, who slit up previously closed and soft palates, to introduce artificial structure. He considered, however, that surgery would accomplish much in this field, and that the time was coming when the mechanical treatment of cleft palate would be obsolete ; the great drawback in the surgical result was that the patient seldom spoke intelligibly. He only remembered one instance where speech became perfect after the operation, and failure was attributable to the fact that the free border of the soft palate in these cases never reached far enough back to touch the pharynx, so as to act as an effective valve, and here the mechanical appliance is far more successful.

Mr. THOMAS BRYANT said that after reading Sir. W. Fergusson's osteotomy paper he was at first sceptical, but now considered the operation a great advance. He wished to know whether, in the infant, silver sutures had actually been passed through the maxillæ to bring the fissures together. Of the old operations on the hard palate more than half had failed. How many of Sir W. Fergusson's forty cases were successful? There was no difficulty in piercing hard or soft palate, but in passing the stitches through, on account of the bleeding, Mr. Bryant introduced the stitches first, which facilitated matters, and reduced an operation of half an hour to a few minutes. He had some doubt as to the dividing of the levator palati muscle in every case, but thought a division of the pillars of the fauces was an improvement.

Mr. ROYES BELL complimented the author on his skill, and stated that the speech in this case, though varying, continued to improve ; the patient could sing. The hæmorrhage in these cases was much less than formerly.

Mr. FRANCIS MASON remarked that Sir W. Fergusson's success was greater since he had divided the bone ; previously he had used an angular knife instead of Langenbeck's raspator, and the sloughing of the parts was due, he thought, to his taking too thin a portion off. The maxillæ had been brought together in infants in America.

Mr. VANDERVEER, U.S.A., questioned if American surgeons did



slit up united soft palates. He had never heard of its being done in America. At Boston Dr. Warren had tried Sir W. Fergusson's operation and failed. He had also attempted it, and had succeeded in uniting the soft palates, but not the hard; he had come to England especially to gain information on the subject.

Mr. OAKLEY COLES referred the last speaker to the 'Transactions of the Odontological Society.'

Dr. CROMBIE recommended the galvanic cautery for dividing the bone, as causing less hæmorrhage than the drill.

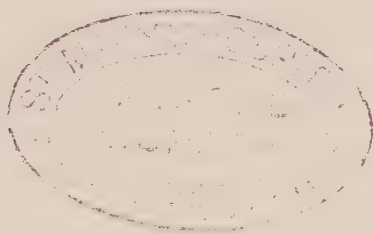
Dr. DRYSDALE thought that obturators were very suitable for improving the voice, and quoted an instance of an actor in Paris, remarkable for his good articulation, who nevertheless had perforation of the hard palate, remedied to some extent by an obturator.

Mr. ACTON used to deplore that syphilitic cases were not operated on in this way, but regretted it less now, as he noticed in the present case the voice was far from perfect.

Mr. MASON explained that his reason for adopting the perforating method was that both Dieffenbach's and Langenbeck's led to extensive exfoliation of the bone.

Mr. GANT was pleased at the thorough discussion that had taken place. After tracing the history of the operation, he remarked that one difficulty was the complete closure of the cleft where the soft and hard palates met; in one case he had accomplished this by the use of heated wire.

Mr. ROSE briefly replied, and the meeting adjourned.



*December 21st, 1874.*

VICTOR DE MÉRIC, F.R.C.S., President, in the Chair.

Mr. SPENCER WATSON read the abstract of a case of

INJURY TO THE FACE, RESULTING IN CLOSURE OF  
THE PALPEBRAL APERTURE OF THE LEFT SIDE;  
FISTULOUS OPENING OF THE ANTRUM ON THE  
CHEEK AND OTHER DISTORTIONS OF THE FEA-  
TURES, IN PART REMEDIED BY A SERIES OF  
OPERATIONS.

The cicatrices occupying the central region of the cheek and the adjacent parts of the nose had caused a depression of the left eyelid, towards the middle of the cheek, in such a way that the palpebral aperture was quite beyond the influence of the levator palpebræ superioris, and its margins were therefore always in apposition, unless when forcibly separated by the fingers; when this was done, the eye appeared to be perfectly sound and vision also perfect. The operation to remedy this condition consisted in transposing flaps of skin from the upper eyelid to the upper part of the cheek below the lower lid, a raw surface having been made in the latter position by dissection of the lower lid from its cicatricial adhesions. The upper lid was thus brought within the range of action of the anterior fibres of the occipito-frontalis, and a certain amount of movement was communicated to it voluntarily by the patient. He thus regained binocular vision. In order to close the fistulous opening in the antrum the margin was pared, and the skin covering the funnel-shaped depression of which it formed the apex was dissected up in the form of three triangular flaps. One of them was turned upwards and inwards, to form an increased cutaneous support to the lower eyelid, and the two lower ones were united by their deep surfaces with a quilled suture. The wounds healed and the fistula has become permanently closed.

The PRESIDENT asked whether there was any discharge from the fistulous opening in the cheek.

Mr. WATSON replied in the negative.

Mr. TEEVAN then read a paper

## ON THE MODERN METHODS OF TREATING STRICTURES.

He commenced by making some preliminary remarks on the pathology, diagnosis, and prognosis of the complaint, and then stated that all the methods of treating stricture might be ranged under the following heads, and that he had tried all except electrolysis.

(1.) The expectant plan, which confined the patient to bed, in the hope that the symptoms would disappear by rest, warmth, and purging. The method was not in favour on account of the sacrifice it entailed on the patient, and ought to be reserved for cases of impassable stricture to enable the surgeon to introduce an instrument; it often completely failed.

(2.) *Continuous dilatation*.—Most useful where gradual dilatation had failed, or when the patient wanted to get well in a few days. In some cases the treatment could not be carried out on account of the irritation it set up.

(3.) *Gradual dilatation*.—This treatment was the most in favour with the majority of surgeons, for it allowed patients to pursue their avocations without interruption, and it was devoid of the slightest risk. There were certain drawbacks to the treatment, chiefly caused by using an imperfect gauge and instruments. If the French gauge and soft French instruments were employed, failures would be rare.

(4.) *Caustics*.—Most useful in certain cases of impassable stricture to open up the mouth of the stricture and enable the surgeon to introduce an instrument. The treatment did not deserve the wholesale condemnation passed upon it.

(5.) *Electrolysis*.—The facts were too few to enable a correct judgment to be formed, the treatment was still *sub judice*; it deserved a fair trial, however.

(6.) The plan of sliding one instrument over another. Useful in cases where there was a false passage, or where the difficulty of treating the case arose, not so much from the tightness of the stricture as the tortuosity of the urethra.

(7.) *Forcible dilatation*, which included the so-called *immediate treatment*, or dilatation forcée, more properly termed “divulsion” by Voillemier and the American surgeons. This treatment was rapidly falling into disuse. In France it had been almost abandoned,



and in Great Britain and America surgeons were constantly relinquishing the practice. In Germany the operation had never been popular. The objections were that it was, as far as could be ascertained, the most fatal of all operations for stricture, the relapses being speedy and aggravated. In London alone a large number of deaths had occurred after the operation, which had never been made public. He always had under his care a number of patients whose strictures had been split up by other surgeons, and whose relapses had often taken place in spite of the most careful attention.

(8.) The various methods of urethrotomy. In France internal urethrotomy was the stock operation for stricture. It was in harmony with all the teachings of surgical pathology and experience, and was making rapid strides in all parts of the world. In this country and in America it was supplanting forcible dilatation. There was little risk, and the results seemed to be more permanent than those following other operations, and he regarded "subcutaneous urethrotomy" as the operation of the future, and preferred it in all cases when it was applicable. External urethrotomy ought to be reserved for cases of horny or resilient stricture, complicated with perineal abscess or fistula. The principles of treating stricture had been correctly summed up by M. Mercier, and might be thus translated—"Dilate where you can, cut where you cannot."

Mr. DE MÉRIC thought Mr. Teevan had been severe on the English surgeons—dilatation he believed to be very useful, but must be well kept up. Cases were different, and required different treatment; it was good to have so many different modes of acting.

Mr. BOND had a case where he took four weeks to pass a No. 1 catheter, and twelve months to pass a No. 12, and the patient now passed an instrument twice a year and has no trouble. He had seen great relapse after splitting, the cicatrix becoming dense and unyielding.

The PRESIDENT preferred the French gauge to the English one, as it was smaller; the sizes in England jump too quickly from one to the other.

Mr. HENRY SMITH spoke of a method Mr. Matthews had carried out, regulating the sizes of the catheters, of which there were fifteen instead of twelve. He asked Mr. Teevan how he would have treated the following case.

A naval officer, æt. 50, a patient of Mr. Smith's, had a bad stric-

ture, and had tried all sorts of metal instruments ; had been dilated with an instrument and the finger in the rectum. The middle of prostate seemed to be enlarged. He had passed a No. 11 bougie, but cannot get on without the finger in the rectum, he having an irregular passage. Mr. Smith does not think a soft bougie could be got into the bladder. The caustic potash treatment got into disrepute by being too frequently used, but he had been saved the use of the knife by the potash, but as the *tactus eruditus* is only acquired by age and practice, the old surgeon leans more and more to the use of dilating instruments. He had seen sloughing of the scrotum after the use of potash, but this may have been from want of caution. As to forcible dilatation, he did not approve of it.

Mr. ACTON thought that splitting was not founded on any principle of anatomy, pathology, or practice. Surgeons should do all they can by the avoidance of powerful injections in the cure of gonorrhœa. Stricture seldom recurs if dilatation has been gradual and not too severe in the first instance. Dr. Vandeeven, of Albany, divided stricture into, viz. 1st of small, 2nd of large calibre ; the first can be made out by the bulbous-pointed bougie, and these do well by gradual dilatation, and being generally complicated with gleet, cure one and you cure the other. He divided the treatment into—1, gradual dilatation ; 2, rapid dilatation ; 3, internal urethrotomy. He spoke of whalebone guides in small strictures, and where no other instrument can be passed, as being very useful, and drew attention to the great exercise of patience which these cases require. He injected warm oil and then made a trial to pass the whalebone guide ; if it went into a false passage he left it alone and went on passing another, and when all the false passages were filled up, one gets into the urethra. (The American scale, so called, had eighteen instruments.) When the passage into the bladder had been gained he followed up the whalebone by rapid dilatation and steel sounds. As the pain in these cases is not great, anæsthetics are rarely given. Dilatation is kept up by the patient himself passing soft instruments at intervals ; strictures in the spongy portion of the urethra are treated generally by internal urethrotomy. He differed from Mr Teevan as regards the use of soft instruments.

Mr. TEEVAN replied.

*January 4th, 1875.*

Mr. C. F. MAUNDER delivered his first Lettsomian Lecture on  
THE SURGERY OF THE ARTERIES.\*

*January 11th, 1875.*

Mr. VICTOR DE MÉRIC, F.R.C.S., President, in the Chair.

Mr. HENRY SMITH related the particulars of a case of

MALIGNANT TUMOUR OF THE LEG REQUIRING  
AMPUTATION.

He was requested to see a gentleman, æt. 51, who was intensely gouty ; six months before he had noticed a small swelling at the middle third of the front of the leg, which, though painless, slowly increased. A country practitioner saw it, and treated it, puncturing it twice, when nothing but a little blood was evacuated. When seen by Mr. Smith it was a soft, somewhat flattened swelling about the size of a medlar, situated over the front of the tibia, just at the junction of the upper with the middle third, adherent to the skin, and gradually slid off to the bone. He at once pronounced it to be a malignant tumour, and recommended that an attempt should be made to remove it, and, if necessary, that amputation should be performed. Another surgeon who was consulted advised the same course, but recommended amputation through the knee-joint, to give the patient a better chance of non-recurrence of the disease. The patient was most anxious to save his knee, and as there was plenty of room to amputate below it, Mr. Smith rather inclined to this view, but as the other and senior consultant expressed a strong opinion against it, he amputated through the knee, sawing off the condyles, and the patient has done well since. On examination, the tumour was found to be of a medullary kind, involving the bone extensively on its surface, and extending deeply down, only, how-

\* A copy of these Lectures is forwarded to each Fellow with this volume of the 'Proceedings.'



ever, for a very limited space, into the medullary membrane; there were several inches of healthy bone between this point and the knee. Mr. Smith was anxious to obtain the opinion of the Fellows upon the question as to whether the better plan would not have been to amputate in such a case through the continuity of a healthy bone, or to cut beyond it through the joint. Eminent surgeons were divided in opinion on this point, and his own old teacher, Sir William Fergusson, was assured from his own large experience, that it was neither justifiable nor necessary to amputate beyond the point where there was plenty of healthy tissue to cut through. Sir James Paget and others, on the contrary, held the opinion that there was much more chance of a recurrence of the disease if the bone involved were not entirely removed. This Mr. Smith thought was a very serious point to settle, as we know for a certainty that amputation of the thigh in a man beyond the prime of life is fatal in 25 or 30 per cent. of the cases, whereas in amputation below the knee the mortality is reduced to at least one half of this, but with regard to the liability of recurrence of the disease being greater or less after each of the operations, there was, as far as he knew, no reliable information.

The PRESIDENT said if he were to be operated on himself he would choose the greater operation, though the rate of mortality was higher in it, to the more serious danger of the disease not being eradicated by an insufficient operation.

Mr. MAUNDER remarked that his principle of acting in these operations was that, the tumour being local, and the constitution not infected, to cut widely round the tumour, so as to ensure its total removal. In a similar case to that of Mr. Smith he cut through the knee-joint with the happiest results, the long anterior flap being used (there being retraction in the posterior) to the extent of five inches. The patient has an excellent stump, and there had been no return of the disease for three years. He advocated the removal of a whole organ if part were affected; in cases of scirrhus we removed the whole breast: why should we not the whole bone when this was attacked?

Mr. BRYANT regretted that Mr. Smith had not given the vertical section of the bone, as then we could have ascertained the exact extent of the cancerous disease. He could not entirely endorse Mr. Maunder's principle as regards the removal of the whole of one organ when attacked with malignant disease, for when the lower

third of the tibia was diseased, surely it was not necessary to amputate at the knee-joint, but in the upper portion of the bone. He highly approved of Mr. Smith's operation at the knee in this case, but criticised his division of the condyles, as this at once produced section of the bone, and exposed the patient to the danger of pyæmia.

Mr. GANT agreed with Mr. Smith, and cited several cases of similar operations which did well.

Mr. ROYES BELL discussed the subject fully, and gave an instance of a child similarly operated on, which recovered in a week.

Mr. SMITH replied briefly.

Mr. BRYANT read a paper on

### THE LEAST SACRIFICE OF PARTS,

which, he maintained, ought to be a leading principle of surgical practice. He explained more fully that the principle is one that forbids the surgeon to sacrifice more of the body than the absolute necessities of the case demand; that calls upon him to remove the disease that requires removal, but no more; that enables him in accidental surgery to make a flap for an amputation whenever he can, and in some cases to make no flap at all, but to leave the case to nature to repair; and in pathological surgery to cut through tissues infiltrated with inflammatory deposits rather than go above a joint. He condensed the subject into three main propositions, each of which he illustrated by cases.

The first proposition was, that in cases of disease or accident no more of the body is to be taken away than requisite, and he illustrated this chiefly from the surgery of the foot. He said that at first sight the proposition might appear to be truism, but he went on to ask any hospital surgeon if it be not true that in cases of disease of the metatarsal bones or joints he was not too apt to regard any individual case as a good one for Chopart's operation, a Pirogoff's, or a Syme's, according to his own fancy or appreciation of the value of one or other of these operations; and if we are not too prone to forget that a good recovery of the foot may ensue on the removal of the diseased bone or bones without any amputation at all. In support of this view he then quoted from the able advocate of Syme's amputation as given in 'Holmes's



System,' second edition, vol. v, who expresses his mature opinion after much experience " that Syme's amputation is calculated to supersede entirely that of Chopart's, besides taking the place of amputation of the leg in the majority of cases formerly supposed to demand it." The author then stated that he entirely dissented from these views of the learned writer; he believed that, from local disease alone, no form of amputation of the foot should be entertained until less severe measures have been employed and failed; that when amputation of the foot is called for, the minimum amount of foot should be taken away; that when a Chopart's operation will suffice, a Pirogoff's should not be thought of; that when a Pirogoff's is applicable, a Syme's should not be entertained; and that an amputation of the whole foot is never to be undertaken when the disease can be removed by less severe measures, for he cordially agreed with Hancock when he asked the question in his college lectures, if anything can be more unphilosophical than to advocate the sacrifice of any bone or joint of the foot for no other reason than that a particular operation should be performed. He stated that the remarks already quoted are as applicable to other parts as they were to the foot, and asked if it were not true that fingers and thumbs were often removed in cases of injury that, if left to nature, might often be saved in order that the surgeon may make a clean amputation. Do we not see joints excised that might be saved by free incisions, or the removal of necrosed bone; and amputation performed above a joint, or high up a limb, in order that good flaps may be made? He then passed on to illustrate all these points by cases, quoting at first seven cases of disease of the different tarsal bones cured by the removal of the diseased bone; and three of external disease treated respectively by Chopart's and Syme's amputation, or amputation of the leg. He then made some remarks upon the wisdom of the surgeon in cases of disease of the bones of the foot, in being satisfied by the removal of the dead bone, never having met with a case in which the resection of a tarsal bone was called for, for bone, he said, that was not dead was reparable, and that to take this away is too often to take away that, if left alone, would make good the parts that have died. The author then proceeded to illustrate the value of the proposition by treatment of cases of diseased joint, and dwelt for some time upon the value of free incision into suppurating joints. He read the headings of thirteen cases successfully treated by this method, and stated his belief that a free cut into a disorganised articulation is



rarely followed by any other than a good result; that when the suppurating process is due to synovial disease, a recovery without further surgical interference may be looked for; when due to local necrosis, the incision helps nature towards the recovery of the case by expediting the process of exfoliation and the subsequent removal of the bone by either natural processes or some surgical proceeding, in more severe cases the incisions giving relief and in no way adding to the mischief. The treatment of disease of the joints due to local necrosis was then considered, and a very interesting series of cases read. Ten cases being given, including examples of disease of the shoulder, elbow, hip, knee, and ankle-joints, in which recovery followed the removal of dead bone from the articulations. The author stated that in no class of cases is the principle of the least sacrifice of parts better shown than in these, and expressed his belief that in one or all of the cases quoted, if this practice had not been adopted, excision or amputation would have been resorted to.

The second proposition was then considered:—That to carry out this principle, the surgeon may in pathological amputations fearlessly divide tissues infiltrated with organised inflammatory products, and even cut through the walls of suppurating cavities or through diseased joints, more particularly to save amputation above a joint. He illustrated this proposition by the particulars of ten cases, in all of which recovery took place.

The third proposition was lastly considered:—That in accidental surgery, parts irreparably injured are alone to be removed, and no healthy tissues are to be sacrificed in order to perform a recognised and probably a named operation, that to these ends the surgeon ought to utilise even doubtfully useful integument, or even leave a stump to granulate, when by so doing some portion of the shaft of a bone can be left, a joint saved, or amputation above a joint avoided.

In the surgery of the hand this practice was strongly advised, more particularly in thumb injuries. Amputation of a thumb, useless, smashed irreparably, the author condemned, and under all circumstances the irreparably injured parts ought alone to be taken away, and doubtfully viable skin left. Amputations were then quoted to illustrate the proposition, viz. ten of the toes, one of the foot, a Chopart's amputation, one of crushed arm (which was left to nature to granulate, and a good stump left), two of crushed legs (in which rapid recoveries followed amputation at the knee-

joint), and one of ruptured popliteal artery treated in the same way with success. The author then concluded by stating that he could still further illustrate the value of the principle, viz. "that of the least sacrifice of parts" from bone surgery, pointing out how Sir W. Fergusson had always urged the removal of tumour of the jaw from within, and Sir J. Paget tumours of bone generally by enucleation. He wound up by expressing a strong opinion in favour of the principle, and said he had for many years acted upon it, and had deviated from it only on very strong evidence of the necessity for so doing.

The PRESIDENT complimented the author on the lucid style of his propositions, but reminded him that attempts to save parts often failed; he would like to know what dressings were used?

Mr. ADAMS remarked that the author's cases involved the great principles of conservative surgery; he briefly reviewed the fall of amputation and the rise of conservative surgery under the hands of Brodie, Syme, Fergusson, and others; excision was first advocated, but now it appeared that Mr. Bryant advocated simple incision into the joints, and he believed Mr. Gay was the first to carry out this practice.

Mr. HENRY SMITH said that Mr. Bryant's views were by no means new; he had learnt the practice of incising joints that were suppurating many years ago from Mr. Gay; it was a mode of proceeding which he highly approved.

Mr. BRYANT, in reply, said he did not in the cases he had mentioned lay any claim to novelty, but advocated the great principle of conservative surgery. The dressing he used was dry lint enveloped in cotton wool, not with a view of excluding germs, but of keeping up an equable temperature.

*January 18th, 1875.*

Mr. C. F. MAUNDER delivered his second Lettsomian lecture on

THE SURGERY OF THE ARTERIES.

*January 25th, 1875.*

VICTOR DE MÉRIC, F.R.C.S., President, in the Chair.

Mr. WOODHOUSE BRAINE related two cases of

HYSTERICAL ANÆSTHESIA OCCURRING IN FEMALES  
BETWEEN TWENTY AND THIRTY YEARS OF AGE.

No anæsthetics had been given, but the apparatus was applied, and both patients became sufficiently insensible to allow of painful operation. In one case several teeth were extracted. In the other two sebaceous tumours were removed from the scalp. On recovering consciousness the patients stated they felt nothing during the operation.

Dr. LITTLETON WINSLOW then read a paper on

RELIGIOUS INSANITY.

He treated the subject metaphysically, considering its diathesis, nature, symptoms, special features, causes social, intellectual, and moral. After a few introductory observations the lecturer passed on to consider religious insanity as an epidemic, especially during the 15th and 16th centuries, stating that by the ancients it was regarded as a Divine inspiration or *flatus*. The epidemic existing in the reign of Francis I, when 10,000 persons were executed whilst under morbid religious impressions, was briefly alluded to, as also the suppression of religious houses at the time of the Reformation, when lunatics, who were called Abraham-men, were liberated from the convents and monasteries and allowed to wander about the country uncared for. Dr. Winslow passed on to consider its diathesis, stating that religious insanity is not, as is supposed by some, "an exaggerated sentiment of religion to be discarded at pleasure," but a disease the result of functional or organic disorder of the brain, and that the morbid infatuation shows itself by running aground on some of the truths or data acknowledged by all the world. We are informed that at its accession it is scarcely discernible, and those immediately associated with the patient are unable to recognise its incubatory stage as approaching mental disorder. Dr. Winslow tells us that the first deviation of the mind from sober reason towards religious insanity is so like an earnest and



truthful warmth of feeling on this all-important theme that we are very likely to be deceived by its ingress, and thus incautiously suffer the enemy to steal a long march upon us before we are conscious of its proximity. It is only possible to arrive at a certain conclusion respecting it by remarking attentively the ordinary behaviour of the religious enthusiast. If the religious fervour tends to render the behaviour and motives of conduct more circumspect, sober, and correct than they have hitherto been, we must conclude that it is not insanity; but if, on the contrary, it seizes hold of new ideas and gives way to eccentric manners or speech, we are wont to suspect the approach of mental disorder. He drew attention to the fact that they who are generally attacked with religious insanity are those who up to the time have lived irreproachably, and have been regarded by their friends as very religious. The disease is now traced through all its symptoms and varieties, and as an illustration of the subject he gave the verbatim language of a patient in whose case he had lately been consulted; the case was a typical one, and well described the symptoms associated with the disease.

He regards all cases of religious insanity as suicidal, and draws attention to the importance of recognising the disease in its early stage so as to prevent any harm occurring to the patient, and, in order to prevent this, supervision in an asylum or the constant care of an attendant is strongly recommended.

In alluding to the intellectual, social, and moral causes, he says: There is in the world a common propensity to create a religion of our own, founded simply upon the instincts of religion. It is, in fact, nothing more than yielding to the instinctive feeling of piety which pervades every breast. By mixing up our private feelings with those in common to the rest of the world without definition or agreement we confuse ourselves, become puzzled or disgusted, and end by setting forth our own individual feelings in the place of the public standard of rectitude. In so momentous a matter as that of death and futurity, which is, in short, the essence of Christianity, the probability is that what is private is wrong, and that what is common is right; for true religion is a revelation from external sources, whereas false religions are hallucinations from within. The external law of the Gospel is binding to mankind, but an internal ideality is not binding, even to the idealist himself. It has been acutely said that man makes his God like himself; whereas Revelation proposes to make man no longer like himself, but like its own

great Author. In an intellectual sense it is from mistaking a particular idea for universal truth that religious madness springs. This disease is a most obstinate and formidable one to treat, and it must be considered as a disease of the brain, and not as a metaphysical alteration and obstruction of ideas, and that its symptoms indicate a disordered cerebral circulation.

The fear of death is one of its moral causes, and when death appears imminent and irretrievable, the patient's mind sometimes becomes so depressed that he never quite recovers from the mental shock.

Religious zeal, one of the special features in this variety of madness, is quite distinct from true religious conviction, as health is from disease. Intense reflection on any one subject, especially if that happens to be religion, is likely to cause the mind to become disordered.

Dr. Winslow concluded with a few remarks on the superstitions prevalent in England at the present day.

Dr. EDGAR SHEPPARD said he had a large experience of this form of insanity, which was on the increase, and could be traced to what might be called religious intemperance. He considered that in the present day religion, like alcohol, was too much adulterated, and that the revivalism of the period contained too many strong elements to be satisfactorily assimilated by weak people of all classes. He related a case of a butler who, after attending a religious meeting in Scotland, was so completely thrown off his mental balance that he refused to have anything to do with his wife and family. He was now an inmate of Colney Hatch, and slowly recovering from his delusion. These people, he said, when ordered by preachers and others to submit themselves to searching examinations, cannot stand the ordeal; they tremble like the intellectual giant Moses did at the presence of the Supreme Being. This form of insanity was very intractable, but those patients who recovered were generally very grateful to their doctors.

Dr. WILLIAMS related the case of a young horse-racer whose previous habits had certainly been the reverse of religious, who attended a revival service and came to the conclusion that he was a doomed man, refused to eat and drink, took to his bed, and endeavoured to learn the Bible by heart. When Dr. Williams saw him a clergyman was kneeling by the bedside, and sundry relatives were weeping around what was supposed to be a dying man, but, under the

influence of alterative medicine and bromide of potassium, the symptoms passed off, and he regretted to say that all religious impressions fled with recovery. He should like to hear from Dr. Winslow whether there was any anatomical basis in post-mortem examination for this disease, as he was under the impression that many cases were dependent on purely functional disorder.

Dr. LEARED thought some degree of mental obliquity must have existed in the case related by Dr. Sheppard; the great mass of mankind could not stand the process of thinking for themselves in matters of religion, and on this point, although he was a Protestant, he could not help thinking the Roman Catholic Church was much to be recommended; it told these weak people what to think, and thus relieved them from much mental anxiety.

Dr. WINSLOW, in reply, said that he had treated the subject from a metaphysical and not a medical point of view; the prognosis depended upon the age and idiosyncrasy of the patient, but was generally unfavorable. All the cases he had seen tended to suicide; he regarded acute mania with a far more favorable prognosis. No special anatomical lesions had been found in post-mortem examinations, and, in his opinion, the ministers of religion were most frequently attacked.



*Monday, February 1st, 1875.*

Mr. C. F. MAUNDER delivered his third Lettsomian lecture on

### THE SURGERY OF THE ARTERIES.

A unanimous vote of thanks was given, with a request for publication.



*Monday, February 8th, 1875.*

VICTOR DE MÉRIC, F.R.C.S., President, in the Chair.

Dr. SANSOM exhibited a boy manifesting a

### PRESYSTOLIC CARDIAC MURMUR.

During the last session he narrated a case in which the diagnosis of mitral stenosis had been verified by the autopsy, and the specimen was shown at a meeting of the Society ('Medical Times and Gazette,' January 10th, 1874, p. 34). The present case was intended to demonstrate the phenomena of mitral stenosis in the living patient.

The boy, *æt.* 9, had been delicate and short of breath from birth, had never suffered rheumatic fever or articular pains, but came of a rheumatic family. There was every reason to believe that the disease was congenital. He never manifested cyanosis, and when quiet suffered no distress; exertion caused palpitation and dyspnœa.

The apex-beat was felt just below the sixth rib and within the nipple line; internally to it was felt a marked thrill, presystolic in rhythm. Auscultation revealed a churning or rolling murmur, heard most intensely internally to the apex, carried up to the left axilla, but lost at the back and over the base. The murmur strictly occupied the presystolic period, being terminated by the sharp thud of the ventricular impulse. In the third interspace the auricular contraction caused a vibration visible to the eye, by means of a pin, which transfixed a small circle of adhesive plaster; this vibration was rendered distinct, and when the lever thus produced was elongated by a little roll of tissue-paper, and its movement, compared with that of a similar lever adapted over the apex of the heart, it was easily seen that the (*a*) auricular preceded the (*b*) ventricular contraction. The auricular contraction was timed as contemporaneous with the murmur, and thus the auricular origin of the sound was demonstrated.

Dr. ROBERT LEE discussed the subject of presystolic murmur somewhat fully, and differed from the author in considering that in this case the murmur was not entirely presystolic, but lasted

throughout the systole, and was probably owing to a congenital deficiency in the septum.

Dr. THEODORE WILLIAMS examined the patient, and gave his opinion that in addition to the presystolic murmur there was a well-marked systolic one, owing probably to mitral regurgitation, and that the disease was probably congenital.

Dr. T. S. DOWSE read a paper on

### THE RELIEF OF PAIN BY THE EXTERNAL USE OF CHLORAL.

He first referred to the fact that, until the last few days, he was not aware that Dr. Dujardin Bannet, of Paris, had largely experimented on the local use of this drug. He thought that in English medical literature sufficient publicity had not been given to the valuable aid which it afforded for the relief of pain and cleansing of parts by its external use.

Dr. Dowse then detailed twelve cases which, in his opinion, were typical examples, to demonstrate the mode of the action of this drug, and the means adopted by him for its application. He uses four solutions, namely, a simple solution of four drams of chloral to one pint of water, a solution with glycerin, a solution with perchloride of iron, and one with chloride of zinc. In the cases which he narrated the good effects of this agent were really remarkable.

For instance, a patient suffering from cancerous ulceration of the left breast, much emaciated from want of sleep and continued pain, and who had been taking large doses of chloral and morphia internally until it was valueless, was most markedly benefited by the local application of chloral. The surface of the ulcerations became healthy by comparison, the discharge less offensive, and the pain was reduced to a minimum. The same good results were obtained in cancer of the uterus, phagedænic ulcerations, eczema impetigo, ulcerated legs, herpes zoster, reflex excito-motor movements of the lower limbs in disease of the spinal cord, pleurodynia, and neuralgia. In those cases where there was no ulceration of the skin Dr. Dowse exposes the subdermic nerve periphery by a vesicant, and then applies the solution of chloral. He did not believe in the existing theory that chloral relieved pain merely by producing sleep, in which case M. Demarquay and others maintain that hyperæsthesia is produced.

The relief from pain by the external application of chloral was not

effected by its absorption into the blood, and by its direct action on sensory motor centres, but rather by direct action upon peripheral nerve terminations.

The PRESIDENT remarked that the author's suggestions were very valuable, but thought that the extract of opium, if used in the same way, might prove equally efficacious.

Dr. THUDICHUM read a paper on

### THE CHEMICAL STATICS OF THE BRAIN.

He premised that the study of brain statics lay at the base of brain physiology and pathology, and that, without a knowledge of the chemical relations which the various principles bear to one another, we should never arrive at laws for the administration of those medicines which act, or we think act, on the brain. Brain matter was composed of 80 per cent. of water and 20 per cent. of solids, the water being in that species of combination with the solids which Professor Graham has called colloidal, and the large proportion of liquid to the solid viz., four to one, allowed, no doubt, an ample opportunity for mobility of particles. He then enumerated five groups of principles.

1. Albuminous group, which is only represented to a small extent.

2. The phosphorised group of which cephaline was a type.

3. The fatty group, in which neither phosphorus nor sulphur was present; it embraced cerebrine, phenosine, and kerosine.

4. The cholesterine group.

5. Inorganic salts.

He dwelt on the various members of the above groups, and demonstrated the chemical reactions by which they were obtained and distinguished from one another, the chief being their solubility or insolubility in water, alcohol, and ether; he expatiated on the cephaline series, most of which he had discovered, and demonstrated the various combinations by interesting experiments, and a number of specimens, which showed careful chemical research and laborious investigation.



*February 15th, 1875.*

VICTOR DE MÉRIC, F.R.C.S., President, in the Chair.

DR. HABERSHON brought forward several cases of  
DISEASE OF THE ABDOMEN IN WHICH THE DIA-  
GNOSIS WAS OBSCURE.

The *first* case was that of a man, *æt.* 54, who was sent to the hospital almost in a dying state with supposed hepatic abscess. For about twelve months he had suffered from pain in the right side; the pain became severe; there was vomiting and purging, and he rapidly emaciated. On pressure in the hepatic region a hard nodular projection could be felt, and pain extended downwards to the iliac region. There were no evident signs of thoracic disease; the temperature was not increased; the urine was albuminous, the left leg, and afterwards the right, became very much swollen. On inspection, it was found that perforation had taken place at the posterior part of the cæcum from tubercular ulceration, and the fæcal abscess had not extended downwards, as is usually the case, but upwards to the under surface of the liver. The rounded mass in the liver was found to be an old and calcareous hydatid cyst; miliary tubercles existed in the lungs, and several small vomicæ; the femoral veins were obstructed with clot.

In a *second* case the diagnosis was equally obscure. A man, *æt.* 49, who had suffered from weakness and indigestion, was brought to Guy's, complaining of pain in the right side of the abdomen, below the liver, and a lobulated swelling could be detected at this part immediately beneath the liver; at first it was with difficulty separated from the liver itself. The hardness in the region of the ascending colon was tender on pressure; the bowels were gently acted on by free enemata of warm water and by castor oil, &c.; bismuth, &c., was given, and the patient left the hospital considerably relieved. He, however, sank in about a month, and on post-mortem examination it was found that several plumstones were located in a peritoneal abscess between the anterior parietes, the angle of the ascending colon and the liver; the colon had become perforated at its anterior part, and the abscess was localised by

adhesion; it appeared that the presence of the plumstones had set up local inflammation and ulceration in the ascending colon, perforation of the bowel had taken place, and subsequent thickening and contraction of the coats of the intestine. The narrowing of the bowel had become so complete that a steel penholder only could be passed.

The patient, however, died from exhaustion rather than from obstruction of the bowels. Dr. Habershon drew attention to the injurious effects produced by purgatives during the acute state of inflammation of the cæcum, and the relief afforded by them when all inflammation had subsided, and when it was found, as in fæcal abscess, that distension of the bowel prevented the free discharge of pus.

In the *third* case, a blacksmith, æt. 39, was brought to Guy's from the neighbourhood of Bedford; in early life he had suffered from ague, but for twelve months before admission had become anæmic and weak. The spleen was found enormously enlarged, extending to the right of the median line; the blood contained a considerable excess of white corpuscles. Below the spleen in the left loin a round mass could be felt; fluctuation could be indistinctly made out, and as the patient passed a calculus after admission, and another calculus was felt in the bladder, it was supposed that this enlargement arose from suppuration of the kidney. Epistaxis came on, and it was found necessary for twenty-four hours to plug the posterior nares; this plug, however, was the cause of excessive irritation in the neighbourhood, and produced suppuration among the muscles and adjoining parts; death followed in a few days. After death it was found that the enlargement in the loin was a large hydatid cyst, connected with but not communicating with the kidney. There were uric-acid calculi both in the bladder and in the left ureter. The great excess of white corpuscles in the blood gave a peculiar pus-like appearance to the clots of the diseased blood in the veins. The case was one of great interest, and the presence of renal calculi and of hydatids rendered the diagnosis obscure; the disastrous effects produced by plugging the nose indicated the extreme danger of surgical operations in these cases of leucocythemia.

Dr. WILLIAMS remarked that the author had laid before them a wealth of pathological specimens, each of the three cases being sufficient to write a paper on; in the third case there was evident



disorganization of blood, as proved by the post-mortem examination ; but the question arose, whether the red globules were affected to the same extent as the white ; in the first case, the point of interest was the date of the tuberculosis, and whether any connection could be traced between the hydatid disease and the tuberculosis ? The tubercular ulceration of the intestine in Dr. Williams' experience rarely led to perforation, for the process was so slow that sufficient lymph was thrown out on the peritoneal coat to protect it ; he had, however, seen a localised abscess form around these perforations, and the patient then escaped peritonitis : but a burrowing abscess, as had occurred in Dr. Habershon's case, he had never before witnessed.

Dr. SANSOM said that cases of ulceration of the vermiform appendix were generally very obscure ; he related one of a boy who was admitted into the King's College Hospital with acute peritonitis, which was traced to obstruction of the vermiform appendix by a concretion, which was formed of inorganic matter, having for its nucleus the beard of an oat, and on inquiry Dr. Sansom found that the child had been in the habit of eating porridge largely.

Dr. HABERSHON replied.

Dr. C. R. DRYSDALE then read a paper on

### THE ANTECEDENTS AND TREATMENT OF TERTIARY SYPHILIS.

The author of the paper, after alluding to the honour he felt in reading a paper on this subject under the presidency of the eminent pupil and life-long friend of the greatest writer on syphilis in Europe, said that he would, first of all, declare himself a steadfast adherent of the *dualistic* theory of syphilitic sores ; and that he held that, in all true cases of syphilitic infection, an incubation of shorter or longer duration occurred, which was not the case with soft sores. He confessed that he had now adopted the views of Mr. Jonathan Hutchinson, and was in the habit of giving small doses of the iodide of mercury, or of mercury and chalk, when an indurated sore came before his notice, for the purpose of preventing the appearance of the secondary eruptions. Secondary syphilis was very like the exanthems in some cases. He had met with a temperature of 104° F., in the case of a delicate lady with roseola syphilitica. He had for many years treated all cases of secondary eruptions by large doses of iodide of potassium, sometimes with signal benefit to the



symptoms of such patients, (an opinion admitted by very few in this country, with the exception, perhaps, of Mr. Henry Lee,) having been won over in 1860 to the non-mercurial side, by the writings of Mr. Syme, Dr. Hughes Bennett, and Dr. Habershon, followed by Dr. Diday and the School of Christiania; and he could not help saying that he believed that both Mr. Jonathan Hutchinson, Mr. James Lane, and Dr. Fournier had derived their present accurate views as to the treatment of syphilis from having to a certain extent been themselves affected by these views for some years. Mr. Jonathan Hutchinson had treated all cases of indurated sore at the Metropolitan Free Hospital for a long time without mercury; Dr. Fournier, in 1863, was sceptical as to the value of mercury in primary sores; and Mr. James Lane had lately warmly acknowledged the debt due to the non-mercurial school of England, of this century. Dr. Drysdale observed that he was now a convert to the arguments lately put forward by Ricord and Fournier, and now gave courses of mercury of some duration in all cases of secondary syphilis. Tertiary syphilis was only now beginning to be well understood, for Hunter knew nothing of the brain disease, or diseases of the viscera now recognised frequently to arise from the effects of the poison. By tertiary syphilis he meant that group of symptoms which arose far on in the disease; which are not hereditary, and not contagious, as secondaries often are. As to the causes of tertiary syphilis, all cases of syphilis tended to be succeeded by tertiaries, but some had no tertiary stage. Diday used to think that a very hard sore and bad secondary eruptions were proofs that the tertiary stage was likely to appear; but that was, Dr. Drysdale held, quite untenable; for some of the worst cases of tertiary syphilis he had seen had occurred when the early stages had passed almost unnoticed, which occurred frequently in the female sex, who as a rule, in his experience, suffered far more severely from tertiary lesions than men. Old age, scrofula, or tendency to consumption, drunkenness, bad living, and other lowering agencies tended to produce tertiaries; but, even in the healthiest persons, severe and even fatal lesions might ensue in the course of years; and it was always important to tell all syphilitic patients to remember this, should they at any future period be struck with some palsy or ulceration of obscure nature. As to whether courses of mercury could prevent the appearance of tertiary symptoms, Dr. Diday replied in the negative; but Dr. Drysdale had felt convinced by the evidence given by Dr.

Alfred Fournier, of Paris, in some lectures on syphilis listened to in 1871, that careful courses of mercury are very potent means of warding off the tertiary stage. Dr. Fournier said that not more than five per cent. of cases carefully treated by mercury would have any tertiary lesions; whereas a very large proportion of cases treated without it had severe lesions. But Dr. Drysdale said he would like to know how long mercury ought to be given to prevent tertiary syphilis, and whether Dr. Theophilus Ricord was to be followed, who advised a six months' course of mercury to all his syphilitic patients, followed by a six months' course of iodide of potassium, or the advice of Dr. Fournier, who recommended ten months of mercury, spread over two years, with intermissions of expectant treatment. English authors were entirely silent on this point, and he wished to glean opinions on it for his own guidance. Dr. Drysdale said that his own prolonged treatment of secondary syphilis with iodide of potassium had soon taught him that Mr. Syme and Dr. Hughes Bennett had mistaken, when they attributed the appearance of tertiaries mainly to the abuse of mercury. Tertiaries occur frequently when no mercury is given at all. Yet he believed with Sir James Paget that the old way in which mercury was used, before iodide of potassium was in vogue, greatly deteriorated cases of tertiary disease when they arrived, for he had seen many cases to illustrate that position. Many cases not treated with mercury got quite well, and remained well for ten or fifteen years, and, as Dr. Lancereaux said, "Clinical syphilis is often not a grave disease:" but, as there could be no prognosis as to what cases might escape, he agreed with Fournier, that the balance of evidence favoured the giving courses of mercury during the secondary stage and primary lesion. As to the treatment of tertiary syphilis, he would like it to be laid down as a rule of practice, that the main treatment for this stage was the iodide of potassium, and he hoped that ere long the citizens of Dublin might erect a statue to Wallace, the great discoverer of that priceless boon to syphilitic patients. In rupia and pustulo-crustaceous syphilis, mercury was said by Mr. Hutchinson sometimes to prove of most signal service, and this was true; but, in true tertiary syphilis, occurring far on in the disease, his opinion was that the antidote, mercury, was out of place, and for the most part very injurious, whilst the analeptic, iodide of potassium, or sometimes iodide of iron, was the remedy required. In all cases of peritonitis, in nodes on the long bones or on the skull or face; in ozæna, or in



sarcocoeles, iodide of potassium is the only efficient remedy. In tertiary sloughing-throat, it was a grave error to use mercury ; and large doses of iodide of potassium, such as fifteen grains, five or six times a day, might alone sometimes save voice and deglutition. In some rare cases iodide of potassium failed in tertiary syphilis, and then mercury should be tried ; but Dr. Drysdale's experience was that, in lesions of the nerves far on in syphilis, all treatment was sometimes unsuccessful. Virchow and the School of Aix-la-Chapelle had lately much extolled mercury in all stages of syphilis, and especially in the tertiary stage, and deprecated iodide of potassium. Dr. Thiry, of Brussels, had gone so far as to say that iodide of potassium had no effect on tertiary syphilis, unless when mercury had been abused. This was quite untenable, for, with Drs. Perrin and Dolbian, he, Dr. Drysdale, would remark, that iodine of potassium was quite as valuable, when tertiary syphilis had appeared in a person totally untreated by mercury, as in one who had taken the drug for years—nay, more so. Dr. Hardy and Mr. Balmanno Squire also gave both mercury and iodide of potassium in all cases of tertiary syphilis ; but he, Dr. Drysdale, could see not the least use of giving mercury when iodide of potassium was so often all-powerful by itself. The ordinary dose of five grains of iodide of potassium was sufficient, except in urgent cases, such as tertiary angina and ozæna, when the drug should be poured into the system. He had no theory as to the action of iodide of potassium, any more than he had for the power of quinine in ague, or colchicum over gouty pains. The phenomenon belonged to the marvels of the art of medicine, to be admired and communicated to our successors. Such were his present beliefs held humbly, until further evidence and experience should tend to qualify them.

Mr. ACTON said he came to hear the confessions of an active antimercurialist, but was surprised to learn Dr. Drysdale's complete conversion. Syphilis had lately been considered an exanthem like scarlet fever, and he heartily wished it worn out ; unfortunately it was not ; its effects were more permanent. He did not agree that women suffered more than men, examinations at the various London hospitals led him to a different conclusion ; he considered that the chance of a man becoming inoculated depended very much on the state of his health at the time. He remembered the time when every syphilitic patient was given mercury until he became salivated, and at the bedside in every hospital ward a small basin was placed



for him to spit into. Iodide of potassium did wonders in tertiary syphilis, but often required various adjuncts, such as iodide of iron, &c. A curious effect of iodide of potassium was that it converted tertiary into secondary syphilis, and it was in these cases that mercury proved exceedingly useful.

Mr. LENNOX BROWN said that tertiary throat symptoms were three or four times more common among females than in males, and drew attention to the deafness which often followed syphilis.

Mr. DE MÉRIC (the President) dwelt on the mode of administration of iodide of potassium, and remarked that few patients thoroughly carried out the course laid down ; the diagnosis between secondary and tertiary syphilis was not easy. Deafness might be due to syphilitic affection of the Eustachian tube, then it was secondary ; or, again, it might arise from syphilitic disease of the temporal bone, then it was tertiary. A great blunder has been made in accusing mercury of producing tertiary syphilis.

*Monday, February 22nd, 1875.*

VICTOR DE MÉRIC, Esq., F.R.C.S., President, in the Chair.

Dr. DOWSE exhibited to the Fellows a recent specimen of

#### TUMOUR OF THE CEREBELLUM.

It was removed from a boy eleven years of age who was born of healthy parents, and whose own health was good until he was nine years old. At this time he was struck by a brick upon the bridge of the nose, and then, in quick succession, the following signs and symptoms became manifest :—Dimness of vision of the left eye, with weakness in the lower limbs, so that he could scarcely walk without falling. This was followed by obstinate vomiting, constipation, and severe pain over the head, more especially referable to the left eyeball and orbit.

When admitted into the Central London Sick Asylum he was unable to stand and complained of great pain in the frontal and occipital regions. The sight of the left eye was gone, and that of the right was very imperfect. There was complete atrophy of the

left optic disc with spreading neuritis of the right eye. The special senses of hearing and smell were at this time perfect. He was fairly intelligent, but his memory was faulty. There was partial ptosis of both lids—recurrent. There was palsy of the superior oblique muscle of the right eye, but the ocular muscles did not appear implicated. The vomiting and constipation were continuous. No palsy of vesical or anal sphincters: neither was there any of tongue, larynx, pharynx, or vocal cords. There was no actual paresis of lower limbs, but when standing erect there was entire absence of voluntary co-ordinating power in these parts. Beyond this there was no paralysis of voluntary muscle. About a month before his death he became deaf, but the portio dura of the seventh was not affected. His condition remained as described until his death, which took place quite suddenly.

The state in which the brain was found at the *post mortem* was fully described. It was distended with fluid, and although anæmic was of firm consistence.

Upon turning back the flocculi of the cerebellum the roof of the fourth ventricle was found to be pushed upwards, and the superior peduncles pushed outwards; in fact, the entire cavity was greatly distended by a non-adherent foreign body, which became fully exposed when the cerebellar hemispheres were incised.

The growth was of considerable size, lobular in outline, and of soft colloidal consistence, readily breaking down by pressure. It appeared to have originated in the middle peduncle, and to have pushed its way forward into the fourth ventricle. There was some surrounding softening, not extensive, but more particularly confined to the diverging and posterior pyramids, restiform bodies, and posterior surface of the pons Varolii. There was considerable recent hæmorrhage around and in the substance of the tumour.

When examined under the microscope the substance of the tumour in its recent state was found to consist of compound granule cells, interspersed here and there with colloid bodies.

Dr. DRYSDALE asked how long the symptoms had existed before the patient entered the hospital. He wished to know whether there was any headache, and how early the diagnosis of disease of the cerebellum was made.

Dr. ROUTH said it was an old theory that sexual instinct was largely involved in diseases of the cerebellum.

Dr. DOWSE replied briefly.

Dr. C. THEODORE WILLIAMS related a case of

TEMPORARY PARALYSIS IN AN ANÆMIC YOUNG WOMAN, ÆT. 19, IN WHOM NEITHER SYPHILIS NOR HEART DISEASE WAS PRESENT.

She had recently recovered from an attack of bronchitis when she was seized with pains in the head and deafness of both ears, succeeded on the following day by vomiting.

The pains continued for a week, and began to subside, when loss of motion appeared on the left side of the face, with loss of sensation on the right side, accompanied by dilatation of both pupils. An hour and a half later Dr. Williams's clinical assistant found that the pain had ceased and the patient could hear well, but that the right arm was powerless and colder than the left; no loss of power appeared in the legs, and the girl was in good spirits. Two hours later the symptoms of paralysis in the arm had disappeared, but those of the face remained. The pain had returned, and the patient moaned greatly. These symptoms were accompanied by rapid pulse and normal temperature, with some degree of unconsciousness. Four days later the right pupil was found to be more dilated than the left, and there was also slight strabismus. In the course of another week the symptoms entirely disappeared, and the patient left the hospital quite recovered. The treatment consisted of free purgation and moderate doses of iodide of potassium. Dr. Williams remarked on the difficulty of accounting for this train of events, in the absence of both heart disease and syphilis, and suggested that the anæmic condition might have caused coagulation in the cerebral veins and sinuses, and consequent exudation and pressure. It had been well ascertained that an anæmic condition of the blood might, besides the above symptoms, produce coma and death. In Dr. Williams's case, absorption of the fluid exuded had probably taken place, and consequently complete recovery.

The PRESIDENT remarked that it may have been a case of serous apoplexy, or, again, Dr. Williams's view of the state of the blood in the veins may have been correct, but in either case total absorption of the fluid affected had taken place, and Dr. Williams must be congratulated on the result. He could not help noticing the changes which, to his mind, fashion made in the use of drugs. In his day tartar emetic would have been commonly used in such a case, but



now bromide of potassium was in vogue. He wished to know why iodide of potassium was used in addition.

Dr. C. R. DRYSDALE said he would not like to offer any theory to account for the remarkable case mentioned by Dr. Theodore Williams. He had under his care at present a case which puzzled himself greatly. A woman, æt. 34, single, of robust health and strong muscular development, was brought into the Metropolitan Free Hospital about the beginning of January, 1875. She was walking along the street, suddenly fell down, without any loss of consciousness, and was unable to rise, having become hemiplegic on the left side. She had been in hospital since, and the hemiplegia continued unaltered. There was no other lesion of any cranial nerve. The woman had never been ill a day in her life, except when she had smallpox as a girl. On reiterated questioning, however, it was elicited that she had had a slight "fit" about three months before entering the hospital. Dr. Drysdale was at a loss to give any theory for the sudden hemiplegia unaccompanied by any other symptom. The treatment at first was by ten-grain doses of the iodide of potassium thrice daily; and then bromide of potassium was added. It was, he supposed, what was called *epileptic hemiplegia*, but he did not wish to offer an opinion as to the condition of the right corpus striatum.

Dr. FAYRER had noticed that blood containing miasmata and watery fluid allows the easy separation of fibrinous clots which block up some cerebral vessel and cause partial starvation of the brain.

Dr. WILLIAMS, in replying, said that the iodide of potassium was given in addition in this case, in the hope that there was syphilis—hope not telling, in this instance, "a flattering tale."

Mr. W. SPENCER WATSON read a paper on

## OBSTRUCTIONS OF THE LACHRYMAL SAC AND NASAL DUCT.

After some preliminary remarks, the author pointed out some anatomical peculiarities of the lachrymal sac and nasal duct. He divided the obstructions of these canals into (1) temporary and remediable without operative proceedings, and (2) permanent, *i. e.* those either altogether irremediable, or removable by the use of instruments. *Temporary* obstructions form a large proportion of the cases met with in practice and are easily dealt with, but if neglected may become *permanent*. When instruments are required,

Bowman's probes are of great use in discovering the seat of the stricture, and in a few cases in altogether removing it; but in obstinate cases the division of the constricting portion by means of Stilling's knife, and the subsequent use of a large conical probe, has succeeded better in Mr. Watson's experience, and has given less pain and trouble to the patient than by the method of Bowman. In very protracted cases of partial obstruction, and in others in which epiphora remains after the removal of the obstruction, the use of astringent injections by means of the lachrymal syringe has succeeded in effecting a cure. When styles are used, they should be made of *soft* silver or of lead (purified). Four cases in illustration of some of the points brought forward were then read, and two others, illustrating (1) the danger of the use of probes and styles in cases complicated with syphilitic periostitis; and (2) the advantage of non-interference by instruments in cases with syphilitic ulceration of the nostrils, but the great benefit of constitutional treatment as affecting the main disease and its complications.

Dr. DRYSDALE, Messrs. Braine, Bell, Davy, and Macdonagh joined in the discussion which followed.

Mr. WATSON replied, and the meeting adjourned.

*General Meeting, for the Election of Officers and Council,  
March 1st, 1875.*

VICTOR DE MÉRIC, F.R.C.S., President, in the Chair.

AT 7 o'clock the ballot was opened and closed at 8, when the papers were handed to the Scrutators, who in the course of the evening announced that all the officers named by the Council had been duly elected. The Ordinary Meeting then began by

Dr. R. FARQUHARSON relating a case of

UNUSUALLY RAPID ACTION OF THE HEART.

The case on which the paper was founded occurred in Dr. Farquharson's practice in the Coldstream Guards, and was that of a man with aortic valvular disease, who came under medical care for palpitation. After twenty-five days' treatment by digitalis, he was

suddenly seized with most violent and rapid action of the heart, the pulse being 216, the breathing being hurried, and the countenance pale and bedewed with sweat. Whilst Dr. Farquharson had his hand on the wrist, two hours and a half after the beginning of the attack, the heart suddenly stopped, gave several irregular beats, and on resuming, the pulsations were found to have fallen to 104. The man was shortly after invalided the service. Reference was made to cases recorded by Dr. Cotton and others, and more especially to one which had been communicated by Dr. Millett, and where very rapid action of the heart came on after sudden emotional shock.

In considering the cause of the symptoms, the author was inclined to agree with Dr. Handfield Jones, in ascribing them to an exhausted condition of the vagi, leading to suspension of their inhibitory power. This is borne out by the effects of various weakening agents on the heart, and also by therapeutical research, which shows that atropine causes excessively rapid rate of heart by paralysing the pneumogastric inhibitory filaments within its muscular structure. Tonic and stimulating treatment with digitalis seemed to have answered well in most of the cases; but in Dr. Farquharson's case the patient was fully under the influence of digitalis at the time, and this may be ascribed to the property which this drug has of primary stimulating, but secondarily exhausting the vagi, and thus enabling the sympathetic nerves to act unrestrained in increasing the rapidity of cardiac pulsation.

Dr. LEARED was of opinion that dyspepsia and distension of the stomach often produces palpitation: he gives digitalis and strychnia or nux vomica.

Dr. BROADBENT had no explanation to offer concerning the cause of this unusually rapid motion of the heart beyond that given by the author. He had seen four cases of this kind. In some instances he thought that there was risk in giving digitalis, and would prefer small doses of belladonna combined with ether and ammonia.

Dr. FOTHERGILL considered it very difficult to find an explanation of these cases: he remarked that irritation of the pneumogastric produces delay of the heart, whilst if the nerve be paralysed, rapid action supervenes.

Dr. FARQUHARSON replied briefly.



Dr. ALFRED CARPENTER read a paper on the

### RATIONAL TREATMENT OF CERTAIN FORMS OF HEMIPLEGIA.

After a few general remarks upon the natural history of the disease, the author detailed a typical case. In the course of the preceding twenty years he had met with ten, in which perfect recovery had taken place without leaving any evidence of the serious evil which it had been suggested as positive, and in which early death from brain softening had been predicated. The cases in question had all occurred in men in the prime of life; the attack having been preceded by malaise and inability to do ordinary work; nevertheless, the system continued at high pressure, and artificial means were used to keep the machine going. There is a sudden attack of giddiness, faintness, partial or total loss of consciousness, which lasted for a time, then departed, leaving the patient weak, one side being weaker than the other, hemiplegia gradually supervening, motion being gradually lost, sensation sometimes. If the latter is interfered with, it gradually returns, the motion following by much slower degrees. At the end of ten days or a fortnight the limb swells, the skin becomes tender, œdema appears, gradually subsides; muscular rigidity, though in some cases threatening, was not established, and ultimately, at the end of two or three years under the treatment prescribed, the whole of the ten had completely recovered, not leaving any sign of that cerebral disease which had been confidently asserted to be present in some of the cases.

The author considered the probable pathology, and likened their cause to a condition of that which constitutes a kind of thrombus in atonic gout, in which plugging of capillaries appears to take place, œdema follows, then resolution; and from a consideration of the pathology he reasoned out the treatment to be pursued.

*First*, to prevent rupture of cerebral vessels by taking off pressure from within; unloading the vessels through the various excretory organs; keeping the patient's body warm whilst providing him with pure atmosphere.

*Secondly*, giving the stomach as little to do as possible, taking care to provide plenty of diluting liquid, which should be some water medicated with a alight aperient, and making this acid or alkaline, according to the indications afforded by a frequent examination of the urine.

*Thirdly*, providing muscular exercise by the aid of an attendant; and the author in support of this, stated that if the muscles of a paralysed man were manipulated in the manner proposed, it was found that the number of respirations were increased per minute; that the patient did not move from his chair, and thus carbonic acid was more freely excreted, and the *débris*, the result of living, was more certainly got rid of, so as not to put out the fires which were wanted to keep up animal heat.

*Fourthly*, making the patient, who always has a superabundance of fatty matter in his blood, live upon that fat, and prevent as far as possible the introduction of azotized food; interdicting, therefore, beef, pork, veal, pastry, much sugar and rich made-dishes, all partially fermented wine, or beer or spirits.

*Fifthly*, insisting upon a fish diet, at least once a day, with milk and simple food; remarking that if the patient is not hungry enough to eat those, he has still fatty matter about him which wants to be consumed by air and exercise in the manner recommended.

*Lastly*, the author insisted upon the sanitary advantages of the fish dinners prescribed by the Romish church in the early days, and gave it as his opinion that the Friday fish dinner enjoyed by that church had helped to save many a hard brain-worker from a breakdown. He also urged that fish contained that which assists to repair brain waste better than any other food, and quoted Agassiz, the Swiss naturalist, in support of his views.

An animated discussion followed, to which Dr. CARPENTER replied, and the meeting adjourned.

*Monday, March 8th, 1875.*

VICTOR DE MÉRIC, F.R.C.S., President, in the Chair.

The Dinner of the 102nd Anniversary took place at the Criterion Restaurant, Regent Circus. Seventy-two Fellows were present. The Silver Medal of the Society was presented to Mr. Woodhouse Braine, F.R.C.S., the retiring secretary, for special services rendered to the Society.

*Monday, March 15th, 1875.*

Dr. ROUTH, President, in the Chair.

After the reading of the minutes,

Dr. AVELING proposed, Dr. DAY seconded, "That the best thanks of this meeting be given to the President, Officers, and Council, that so ably conducted the affairs of the Society during the past session."

The PRESIDENT warmly concurred in this proposition, and said, in putting it to the meeting, that he was sure such a pleasing vote would be carried by acclamation.

Carried.

*Abstract of Dr. Routh's Presidential Address.*

After a few prefatory remarks, and after passing a high eulogium on their late President, Mr. de Méric, Dr. Routh proceeded to consider in what manner a medical mind could best regulate medical work. Referring first to the Divine attributes and character of mind, he pointed out how strange it was that amid much great and noble work done, yet the mind had in many instances fallen far short of its powers. In religion, in law, and in medicine, there were marked evidences of error, although in the end truth generally prevailed; but in the progress of advancement much violent commotion took place—in medicine especially. In tracing the causes of these he believed, *first*, this was due to a sort of moral Darwinism in its professors, who were prepared for progressive development, but opposed to abrupt and lofty transitions. This error in natural Darwinism he exposed by giving examples of antagonisms in nature, or new platforms; and by analogy the same had existed and would occur in medical science, of which he also gave examples. Special subjects were also *minor platforms*, upon which a medical mind must work, and although to be preceded by general knowledge and controlled within proper limits, were evidences of progress and perfecting, and had been too violently opposed.

*Secondly*, another cause which had arrested progress was that we



were apt to take too material a view of medical science, Facts were often material, but it was the manner in which they were used and explained which made the science. The same facts might be very differently construed. The struggle was one of *mind*, not *matter*. Hence in the confusion some became so wedded to matter that they actually looked upon *mind* as matter, *thought* as a cell secretion or force developed. Combating this view, he pointed out that no matter had yet developed any force *akin* to *instinct*, still less to *mind*. A chemical experiment was very different from a vivisection. Medicines might act very different on animals and man, on hot or cold-blooded animals. Some diseases were obnoxious to animals and innoxious to man. Here were several varied platforms on which the medical mind might work; but to make anything of them at all, the power used must be *mind upon* the matter, and he was only successful as a practitioner who did so. He referred to the Contagious Diseases Act as tending to materialize a woman, although he admitted some moral good might incidentally be done; but feared the army and navy medical officers would themselves suffer from this materialization, their *mental* powers being disregarded, and themselves considered as machines out of order, when proving restive and when wishing to resign would be looked upon as deserters, and without option be dismissed the service.

A *third* cause which had arrested progress was our great disregard to the discoveries of those who had preceded us.

By reference to art and architecture among the ancients, he showed here they excelled us beyond comparison. He showed that the sanitary arrangements in the way of baths of every kind were far superior to that of London; the sewers were immensely larger; the water supply better and continuous, proving that they knew that water found its own level, and preferred running water in aqueducts to underground pipes; that for a thousand years in their census they united a sanitary officer and registrar-general. They had colleges of physicians, of veterinary surgeons, and even midwives.

He then referred fully to the subject of fibrinous concretions of the heart which were discovered by Gould in 1684, and then described by him; and by Chisholm in 1790—all forgotten until, in 1851, Dr. Richardson, one of their distinguished Fellows, had dissected these works, and placed the disease beyond doubt as to

prognosis, diagnosis, and treatment, long before Virchow and other Continental writers had written about embolism and thrombosis.

He then referred to transfusion, originally practised on Pope Innocent VIII by a Jew, in 1492, and forgotten till 1865, when experimented upon by the Royal Society of England; till forbidden in France by prelates it fell into desuetude, till again revived in England by Blundell. He showed from Dr. Aveling's writings what the causes of this oblivion were, and how it was now fully recognised as a prosperous operation.

He next referred to the controversy on the use of the speculum vaginæ, which took place in London twenty-five years ago, showing it was used in the time of Domitian, and had been found among the ruins of Pompeii, and yet had been forgotten for centuries. Now it was everywhere used.

He next dwelt upon the question of cremation and burying in wicker-baskets, both olden customs, yet now remembered and likely to be employed again.

A variety of obsolete practices now coming in vogue were cursorily mentioned, all of which proved we erred in neglecting ancient usages in practice, among which there were many still forgotten which could be readopted with great advantage if sought after and disinterred.

The President concluded by a peroration, pointing out the great discoveries of modern times and looking forward to the grandest results in the future from the combined experience of the past and present.

Dr. JAGIELSKI read a paper

### ON SPIROMETRY,

illustrated by a new instrument, diagrams, and tables, before the Society, which was never before noticed in that place. He first gave a definition of the word spirometry—vital capacity; passed over the whole history of spirometry from the beginning to the present time, paying especial eulogium to the great John Hutchinson; in this history were considered the writers on that subject in England, Germany, France, and Holland. The vital capacity is two-fold: general and individual, and (A) under *normal* circumstances, and in a healthy condition of the body, it may be influenced by six factors: the height, the weight, the thoracic mobility, thoracic circumference, age, and posture, each of which he (Dr. Jagielski)



considered in detail. Having given an explanation of the terms used in physiology—breathing air, complimentary, residual, reserve air, he referred to the difficulties connected with spirometry for practical purposes in diagnosis. Under B, he gave the vital capacity under abnormal circumstances, or unhealthy conditions of the body, the result of which produces *deficiency* of vital capacity from general causes of disease, local causes, and real tendency to pulmonary consumption. Many instances of spirometrical early diagnosis were adduced from literature to illustrate those facts. The tables of vital capacity in relation to height and in disease in relation to the first, second, and third stage of phthisis were explained. Chronic and acute miliary tuberculosis were described, and the value of the use of the spirometer in their earliest commencement shown. The objections of authors, he mentioned, proved how untenable they were and unjust. The *individual* standard of vital capacity is of greater value than the *general* for diagnostic purposes; especially useful spirometry will be in those instances where no other mode of investigation can give us a hint or warning to exclude a man from a certain work, for which the spirometer will point him out as thoroughly unfit. There is often opportunity for it in this respect in the army, prisons, workhouses, manufactories, hospitals, and in the private practice of every physician.

Under C, Dr. Jagielski considered the excess of vital capacity upon which he looks always with pleasure and satisfaction in the healthy man as well as in the diseased, as several cases prove, which he mentioned in full. Excess of vital capacity depends either upon greater thoracic mobility or elasticity, or upon lungs extending far downwards. Excess of air is always more favorable and amenable to treatment than deficiency of vital capacity.

This paper was followed by an explanation of Dr. Jagielski's new spirometer, made by Messrs. Mayer and Meltzer, Great Portland Street. This instrument is only seven inches high, and weighs but five pounds fourteen ounces; it is easily portable, correct, durable, and of a very decent appearance, being cased in leather, with a leather handle at the top.

Dr. THEODORE WILLIAMS testified to Hutchinson's labour. At Brompton Hospital his spirometer was not much used, because the patients require education in doing so. The instrument is useful in suspicious cases of tubercle, but of no practical value where tubercle is largely present.



Dr. LEARED thought the instrument useful in obscure cases, and regretted that its use was discontinued at Brompton Hospital. He showed his own instrument for measuring mobility of the chest.

*March 22nd, 1875.*

Dr. ROUTH, President, in the Chair.

Mr. F. J. GANT related a case of

EXCISION OF THE TONGUE FOR EPITHELIAL CANCER, LEAVING THE FLOOR OF THE MOUTH ENTIRE; RECOVERY, AND NO RETURN OF THE DISEASE AFTER A YEAR AND FIVE MONTHS.

In this interesting case, the patient, a man, æt. 70, and otherwise in robust health, was the subject of a cancerous ulcer of the left half of the tongue, which had been removed by Mr. Gant on two previous occasions with a bistoury, but the ulcer returned each time in the course of a few months. Yet the submaxillary glands remained unaffected. Under these circumstances, the man was readmitted into the Royal Free Hospital, and it became necessary to excise the whole organ; this being accomplished by an operation, which was performed in the following manner:—Chloroform having been administered, an incision was made on the left side from the angle of the mouth through the cheek, inclining downwards to the jaw, at the junction of the ramus to the body of that bone, thereby gaining free access to the root of the tongue. Then drawing the tongue well out of the mouth with a forked vulsellum, having a catch spring to hold fast, two curved aneurism needles were passed deeply through the base of the tongue from before backwards, one on either side of the frænum, and their points made to emerge just in front of the epiglottis, the soft palate being protected with the forefinger of the other hand. A strong écraseur, having one end of the chain unlocked, was then cast round the base of the organ, under the needles behind and in front, which thus kept the loop well down around the

whole tongue. The *écraseur* was worked slowly, at an interval of two minutes, afterwards a minute, and lastly half a minute, between each action of the handle; while the curved form of the needles guided the chain deeply down through and along the floor of the mouth. The tongue was thus entirely removed in a period of thirty-eight minutes. No hæmorrhage took place during this procedure; and after removal of the tongue, the floor of the mouth presented a smooth, dull-red surface, without any bleeding. The incision through the cheek was accurately closed with stout hare-lip pins and twisted sutures. In the course of operation the influence of chloroform was maintained by inhalation through the nose.

The patient swallowed a few spoonfuls of fluid the same evening, and slept for several hours in the night. On the fifth day, the cheek-incision had healed entirely by primary union, and the pins were removed. At that early date, he could speak with sufficient articulation to say, "I feel easy," and "I should like some more beef tea." The act of swallowing liquid food was perfect. Since that time, the floor of the mouth, especially at the base of the tongue, has acquired a free movement up and down, as if of the tongue, in relation to the palate; and thus speech and deglutition have become more complete. But labial articulation is imperfect, and attended with some dribbling of the saliva. This inconvenience, however, is slight in the history of such a case. The man has resumed his former occupation, that of a cab-driver.

Mr. ARTHUR DURHAM preferred the galvanic cautery to the *écraseur*; the instrument is smaller, and there is less crushing of tissue, the wire should not be too hot, nor used too quickly. He usually opens the floor of the mouth at the side, and not in the median line, so as to avoid division of the mental origin of *genio-hyoides* and *genio-hyoglossi* muscles. In one case, where these muscles had been so divided, impending suffocation necessitated tracheotomy. The wire was then passed with greater facility around the back of the tongue. Mr. Durham mentioned that the top of the epiglottis in this as in the other cases was doubled up, caused, he thought, by a contraction of tissue between the tongue and epiglottis.

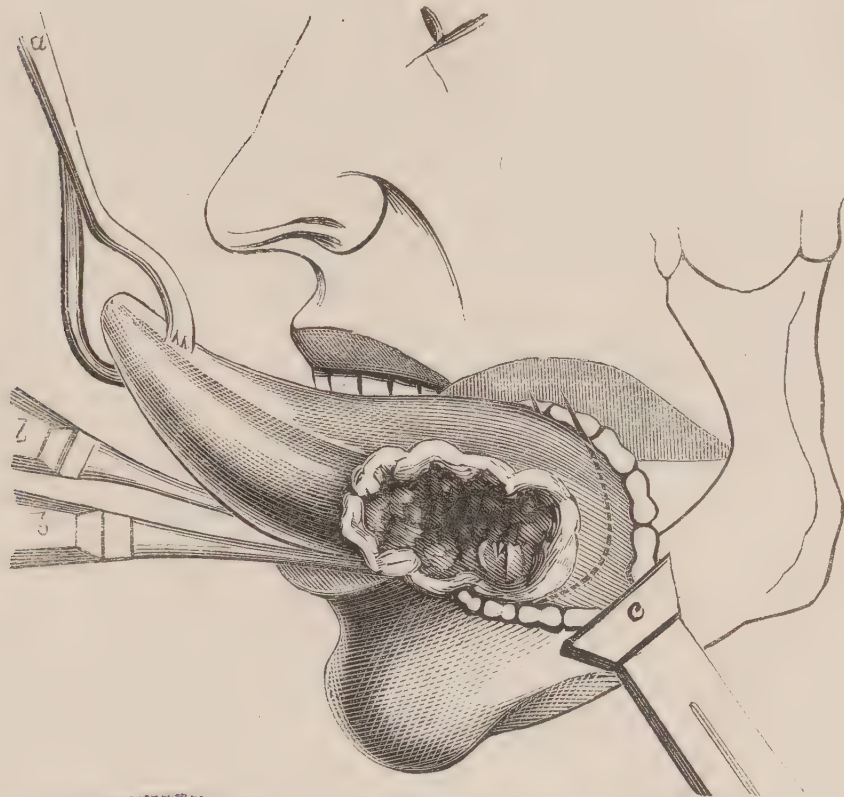
Dr. THEODORE WILLIAMS exhibited a striking case of

#### ARRESTED PHTHISIS,

which he had first seen in consultation with Mr. Kempster, of Battersea, in January, 1871. The patient, a banker's clerk, æt. 27,

*Mr. F. J. Gant's Case of Excision of the Tongue.*

FIG. 1.



- a.* Vulsellum Forceps. *bb.* Needles to guide the Écraseur Chain.  
*c.* Écraseur.

FIG. 2.



The Tongue removed.





had been suffering for a year from fistula in recto, from which there was now a free discharge. In the last month he had been attacked with symptoms of rather acute phthisis, which were rapidly progressing. The cough was very troublesome; the afternoon pyrexia high; and the emaciation rapid.

Both lungs had become extensively involved, and softening was detected in the upper lobe of the right. In February he had pleurisy of the left lung, and shortly afterwards the expectoration became very profuse and purulent. On the 13th, cavernous gurgle was detected in the first intercostal space, and the symptoms somewhat improved. At the end of the month the cough became worse; the expectoration more profuse, temperature and pulse rose again, and the cavity in the right lung was found to have considerably extended, and to give rise to amphoric tinkling sounds, audible over a considerable portion of the right front chest.

After this the patient improved steadily, the febrile symptoms subsiding; but on March 24th tinkling cavernous sounds were still audible in the right chest.

Two months later considerable improvement had taken place, and on careful examination, Dr. Williams was surprised to find that all signs of a cavity had passed away, and beyond some dulness and tubular sounds, nothing was to be detected.

Dr. C. J. B. Williams, who had seen the patient in the early part of his illness, examined him on this occasion, and was also unable to detect any signs of cavity.

The cicatrization of the cavity had taken place without causing any displacement of the neighbouring organs, nor did any shrinking of the chest wall occur, the affected side being at the present time larger in circumference than the other, owing to emphysematous changes having taken place in the lungs. Nine months later the patient returned to his work, which he has been following without interruption ever since.

Up to the present date he had gained three stone in weight since his illness: he can walk five or six miles a day without losing breath, and to judge from his appearance, he is the picture of health. He still has cough unaccompanied by expectoration. The fistula remains open; the physical signs are much the same.

Dr. SYMES THOMPSON considered the symptoms due to an inflammatory condition, which on breaking up gives rise to tinkling.

Dr. FOTHERGILL asked, how big was the cavity?

Dr. DRYSDALE narrated a case of recovery from phthisis, and stated that among the phthisical poor the average duration of life was two years.

Dr. BROADBENT thought the size of the cavity had been exaggerated, and that the surrounding induration had increased the sounds by conduction. He asked for dates of attack, profuse expectoration, and first and last observation of tinkling.

Dr. WILLIAMS replied; he considered Dr. Drysdale's experience an unhappy one, and gave his own experience that eight years represented the average duration of phthisical life among the higher classes.

Dr. BROADBENT read a paper on

### ILLUSTRATIONS OF DIFFERENT FORMS OF URÆMIC POISONING.

Diseases of the kidneys may prove fatal in various ways. One mode of termination is by dropsy; fluid accumulating in the areolar tissue and serous cavities to an amount incompatible with life, the immediate cause of death being effusion into the pleura or pericardium. Death simply from dropsy, or, as it may be called, hydæmia, is however rare, and I have seen it only in acute desquamation or tubal nephritis. Another way in which renal disease destroys life is through the occurrence of inflammations, of pleuro-pneumonia, pericarditis, &c., due to the deterioration and poisoning of the blood, by which the relations between the blood and tissues are disturbed.

A third, by uræmic poisoning, however, as generally understood, presents the effects upon the nervous centres of retained urinary matters. These effects are very different in different cases, and though it is recognised that the poison is not always the same, that there is certainly sometimes ammoniacal decomposition of urea within the system (not necessarily in the blood itself), that at other times there is no ammonia, and probably no excess of urea in the blood, but some nitrogenized waste material which has not been completely oxidized into urea, we are not yet able to refer the particular forms of urinous poisoning to the special poisonous agent, and I shall not attempt to do this on the present occasion. What I propose is simply to give outlines of cases which have come under my notice, illustrating the diversities of which I have spoken.



CASE 1.—A domestic servant, æt. 31, was admitted into St. Mary's Hospital, under my care, April 12th, 1872.

She was not supposed to be ill till six weeks previously, though for three or four years the urine had been thick, and she had occasionally had pain in the back and difficulty in micturition. When one morning she went to answer the door she found she was unable to speak, all her attempts resulting only in a sort of hiss. She was dizzy, but did not fall or lose consciousness. This loss of speech lasted six hours, and she had done no work since, though she had been up and about. She had vomited from time to time.

On admission she was pale, sallow, and very weak, and complained of pain in the epigastrium, left side, and back. The urine was pale, deposited much yellow pus, had a specific gravity of 1010, was alkaline but not ammoniacal. It was passed frequently, and the quantity was large. The catamenia were regular; there was a purulent vaginal discharge.

On the 15th, she was rather stupid in appearance and in her replies. She felt poorly and languid, complained of pain in her legs, said she could not "work her jaws to eat," it was such "hard work." She was pale, the nose was very red, which had not been observed before, and two new symptoms of great significance were noted. The breath had an ammoniacal odour, and there was incipient nasal stertor, by far the most serious form of stertor. Tongue clean; bowels confined.

Heart hypertrophied; slight reduplication of the first sound over the septum; no valvular murmur; pulse 112, small and weak, but long, the artery remaining full in the intervals.

Fundus of eye pale, and having a peculiar look; nothing specially abnormal about optic discs.

16th.—Delirious, restless, sleepless, trying to get out of bed. Tongue dry, throat sore; refuses to swallow. Appears to understand but will not speak. Nasal stertor very loud.

Gradual death next day from asthenia.

The kidneys were in a most advanced stage of tubercular disease, the right being represented by a large sacculated cyst, with contents resembling curds and whey; the left contained several cavities, full of pus and *débris*.

There was also tubercular disease of the Fallopian tubes. Uterus and ovaries small. Old tubercles in lungs.

CASE 2.—Emma F—, æt. 18, a general servant, was admitted into St. Mary's Hospital, under my care, July 3rd, 1874. She had been doing her work till within three or four days of her admission, but for three weeks had suffered from constipation, and the bowels had not been open for twelve days when she came under observation. The catamenia had been absent for twelve months.

She had the appearance of a patient in a late stage of severe typhoid fever. She was prostrate, listless, took little notice of what was passing; the face was flushed; the mouth partly open; the teeth covered with sordes; the tongue dry and shining at the tip. The skin, however, was cool, and the temperature only  $98.2^{\circ}$  Fahr. There was no abdominal distension or tenderness. There was great excoriation about the anus, and a profuse discharge from the vagina. The urine had the sp. gr. 1003, was acid, and contained albumen; it was covered by a thick brown scum, probably formed by the vaginal discharge mentioned. Pulse 100, very weak.

4th.—The bowels were relieved, but the motion was scanty and hard, and passed with great pain. General condition much the same.

She lay in this state gradually becoming weaker, and more dull in intellect; the pulse also became more frequent. Temperature remaining at  $98^{\circ}$  F. On the 7th she was very restless and on the 8th convulsions came on, followed by coma, and speedily death.

The peculiarity in this case consisted not in the mode of death, for convulsions are a common termination of uræmia, but in the antecedent symptoms.

CASE 3.—Emma W—, æt. 40, came under observation Jan. 29th, 1875. She had been a servant in the same family for many years, was trusted and respected, and had little work. She had had no serious illness, but did not consider herself strong. For some months had suffered from rheumatism in the arms and legs, which, however, had not prevented her from doing some little work; it was ascertained also after her death that she had shown peculiarities for some little time.

Her complaint was of rheumatism and weakness. She could not raise the right arm, and some effusion into the shoulder-joint was detected; the deltoid and scapulo-humeral muscles were powerless and greatly atrophied. She was thin, sallow, and pale. The pulse was frequent and very weak, and the artery was full in the in-

tervals, and could be rolled under the finger. Temperature 98° F., urine pale, specific gravity 1012, contained much albumen ( $\frac{1}{4}$ ) and pus.

Feb. 1st.—Complaining of pain in the arms and legs; no sleep. A uræmic or modified urinous (not ammoniacal) odour of the breath detected.

3rd.—Great pain; no sleep; absence of appetite, and a feeling of sickness; urine sp. gr. 1010; much albumen ( $\frac{1}{4}$ ), acid. Uræmic odour of breath was pronounced. Though she answered questions properly, she dropped off to sleep while under observation; startings of the muscles observed.

4th.—Half unconscious, still complaining of pain. Breath and perspiration uræmic. Became very rapidly worse, and died at 6 a.m. of the 5th February.

The disease here was tuberculous. The left kidney was entirely destroyed, and was represented by two cysts containing white mortar-like matter, consisting of fat and pus cells. The right presented at its upper part a cavity with contents such as that of the cysts in the other kidney, and in the rest of the organ were patches occupying left cortex, and pyramids infiltrated with deposit in various stages of degeneration.

A large number of bronchial glands were found to have undergone cretaceous change, and it is not improbable that disintegrated caseous or purulent matters absorbed from these glands may have set up the disease in the kidneys by infection.

CASE 4.—Ann V—, æt. 50, a nurse, was admitted under my care March 20th, 1872. She had been ailing for some years. In September, 1871, had a maniacal epileptoid attack, and afterwards almost weekly convulsive seizures, always beginning in one or other foot, sometimes proceeding to loss of consciousness, sometimes not.

Her memory was weak; her appearance and ways strange, and like those of a person insane; her expression anxious and imploring. She had not confidence to walk alone, but a mere touch enabled her to walk quite well and quickly. Her face was pale and had a leaden hue. Appetite good; bowels open; sleep excellent. Pulse 108; artery full between the beats. Heart sounds muffled, equidistant, and almost alike, calling to mind the sounds of the foetal heart. Urine albuminous. By ophthalmoscope, numerous retinal hæmorrhages seen.



30th.—Saying and doing odd things for the last few days; “out of her mind;” troublesome, especially in the night.

April 2nd.—Lobular pneumonia at the base of both lungs, which on the 6th was apparently better.

11th.—An attack of convulsions, almost fatal at the moment. An hour and a half later she was restless and moaning, not unconscious, but not doing what she was told. She never spoke again, and died next day.

*Kidneys* in the contracted granular condition, but not in an extreme degree.

*Heart* dilated and hypertrophied; no serous valvular disease.

*Brain*.—Membranes singularly lacerable; extensive disease of cerebral blood-vessels; brain substance pale and rather soft.

A common mode of death by uræmia is, that without previous symptoms of sufficient importance to attract attention, the patient is suddenly seized with convulsions, which end in coma and death. Cases of contracted kidney occurring in early life are specially apt to terminate thus, and convulsions are very common in scarlatinal albuminuria. As my object has been to bring forward cases in which the usual order of phenomena in uræmic poisoning has been departed from, I do not give illustrations of these.

Owing to the lateness of the hour, a short discussion only ensued.

*April 5th, 1875.*

H. ROYES BELL, F.R.C.S., Vice President, in the Chair.

INJURY SIMULATING EXTRAVASATION OF  
URINE.

Mr. HENRY SMITH stated as follows :

“I was called to see Mr. H—, æt. 55, who had been in weak health for some time. I had attended him in the previous summer for a bad varicose vein; and, although I had known him many years, had never heard him complain of any symptoms referable to the urethra or bladder. He was given somewhat to the free use of stimulants. I saw him on the afternoon of March 3rd. I found him in the following state:—The scrotum was largely swollen, and the skin over the greater portion was destroyed, as though by fire; there was considerable redness and swelling extending upwards along each inguinal region towards the flanks, and there was considerable swelling in the perinæum, but there was not any mark or sign of a wound; his pulse was rapid, and there was general depression. I ascertained that on the evening of the first two days only, whilst playing with his children, he had fallen upon the edge of the sofa on his perinæum and felt some pain, but the same evening he took a walk, returned home, complaining of severe pain and was put to bed. Twenty-four hours after the accident Mr. Marshall, of Mitcham, saw him, and found the scrotum very much swollen, when my assistance was sought. The symptoms presented all the appearances of extravasation of urine, but the patient did not complain of any difficulty in making water. I was enabled to pass a large catheter easily into the bladder and drew off the water. I was puzzled at this; and stated that although there was no evidence of any extravasation, I thought it best to make an incision into the perinæum. Mr. Marshall agreed with this, and I made an incision, but did not evacuate anything but blood. This gave relief, but the symptoms went on increasing with great rapidity, extensive disorganization of the scrotum and penis, and increase of the inflammation

in the groins and sides of the belly took place, and the patient sank on the 7th, six days after this slight injury ; no urine whatever coming away by the wound, and he being able to pass water freely. The question is, whether in this case it was one of injury to the urethra, or simply severe inflammation simulating extravasation."

Mr. W. ADAMS could not help suspecting the existence of albuminuria, on account of the disorganised condition of the parts.

Mr. HAINWORTH had published several cases of rupture of the urethra, in none of which a catheter could be passed after the accident ; but subsequently an instance occurred in St. Thomas's Hospital, where the patient had a catheter passed, and the diagnosis was,—no rupture of the urethra. On *post-mortem* examination, it was found that extravasation of urine had taken place, and the urethra was burst.

Mr. HENRY SMITH, replying, said there was no kidney disease in this case.

Mr. LENNOX BROWNE read a paper, entitled,

#### CONSIDERATIONS ON THE TREATMENT OF NEW FORMATIONS OF BENIGN CHARACTER IN THE LARYNX,

in which, after alluding to the fact that since the larynx had been brought fully under the control of the observer and practitioner, operations had become more and more bold and frequent, he submitted the following propositions:—"1. That the symptoms occasioned by benign growths in the larynx are, in a large proportion of cases, not sufficiently grave to warrant instrumental interference. 2. That many of these new formations, especially when of recent occurrence, disappear or are reduced by appropriate local and constitutional medical treatment. 3. That attempts at removal of growths from within the larynx are not in themselves so innocuous as is generally supposed ; but that, on the contrary, direct injury of healthy parts of the larynx, leading to fatal results, is by no means of unfrequent occurrence. 4. That recurrence of laryngeal growths after removal, *per vias naturales*, is much more frequent than is generally supposed. 5. That further, while malignant or cancerous growths are of extremely rare occurrence within the larynx itself, benign growths not unfrequently assume a malignant, and even cancerous character by the irritation produced by attempts at removal.



6. That the instruments most generally now in use are far more dangerous than those formerly employed. 7. That the cardinal law, that an extra-laryngeal method ought never to be adopted unless there be danger to life from suffocation or dysphagia," should be applied with equal force to intra-laryngeal operations; and that it is a subject worthy of consideration whether, in many cases, tracheotomy alone might not be more frequently performed (*a*) with a view of placing the patient in safety when dangerous symptoms are present; (*b*) in order that the larynx may have complete functional rest; and (*c*) as a preliminary to further treatment (radical or palliative).

Considering in detail these various points, the author showed that the sole symptom in over 50 per cent. of cases of growth submitted to operation was simple impairment of voice, while dyspnœa had been present in only 30 per cent., and dangerous dyspnœa in only 15 per cent. He quoted cases to show that early medical treatment, local and constitutional, of many of these growths, was often successful; he showed how easy it was in these operations to injure healthy parts; gave instances in which recurrence took place even while under surgical treatment, and of others in which benign growths assumed a malignant type after surgical interference. He exhibited the earlier and the more modern instruments employed for these cases; and finally trusted "that, looking to the many evil consequences likely to result, and actually resulting, from attempts at removal of growths from the larynx, by the laryngoscopic or any method, the profession would consider the proposition established, that there is not, so commonly as is supposed, any operative procedure for the treatment of these cases, in which "no chance of danger is incurred."

Dr. DRYSDALE remembered a case of polypus of the vocal cord, in which complete recovery had occurred without any operation; but in some instances it was of vital importance, as in the Stutgard case, where the patient died of asphyxia, from the presence of a laryngeal growth which could have been easily removed by the forceps.

Dr. CRISP asked whether the author could classify the cases where he considered operation justifiable.

Dr. THEODORE WILLIAMS was surprised to hear from the author that the treatment of hyperæmia preceding the tumour would put a stop to the appearance of the tumour in the larynx, as it must be obvious that the after-growth of the tumour depended upon its

nature, which, if malignant, nothing would impede. A large number of these growths were the result of syphilis, and under iodide of potassium and local treatment disappeared; it was, however, difficult to extract a history of syphilis; and the best rule was, when in doubt, to give iodide of potassium.

Mr. MASON did not subscribe to Dr. Williams' dictum about iodide of potassium, and asked for the history of two of the author's cases, alleged to be syphilitic.

Mr. BROWN, in reply, stated that laryngeal growths existed in half per cent. of throat diseases. The nature of the growth was not necessarily material to its treatment; but he thought it only fair to the patient, that the danger of operation should be plainly stated to him before anything of the sort was attempted. In reply to Mr. Mason, he stated that the patient alluded to had psoriasis palmaris, and well-marked syphilitic sore throat.

Dr. BRUNTON then read a paper on

#### ACCIDENTAL CONCEALED HÆMORRHAGE,

which he illustrated with drawings. He pointed out the rarity of the disease, no cases having been recorded during the last ten years, and quoted a remark of Dr. Braxton Hicks ('Obs. Trans.,' vol. ii, p. 78), that the infrequency of concealed accidental hæmorrhage makes it the more important that every case which occurs should be fully reported. In his own practice Dr. Brunton had had four cases, and had found details of a few more, which, added to twenty-three gathered by Dr. Hicks, made thirty; and out of these, nineteen were fatal to the mothers and the children were all born dead. In his own cases all had recovered, which circumstance he attributed to his mode of treatment, which was *not* to rupture the membranes early, as recommended by every one else.

An analysis of the recorded cases showed that, in nearly all the instances where the membranes were torn early, the death of the mother followed. Doubtless it was the general opinion that early rupture of the membranes hastened labour; but it was a great mistake, as every one engaged in active or extensive midwifery practice could testify. As long as the blood extravasated between the uterus and placenta and the membranes was detained there, of necessity there was a limit to the hæmorrhage; but as soon as the membranes were broken and the waters evacuated, there was relaxation of the hydrostatic conditions, further separation of the placenta, bleeding and

great danger, if not death. His mode was to rally the patient by stimulants, food, and perfect rest, until sufficient relaxation of the parts had taken place to facilitate rapid (but not too rapid) delivery. He gave the particulars of five cases successfully treated in this way, the diagnostic symptoms being alike in each, viz. (1), sudden fainting, collapse, and blanching; (2), continuance of the same, more or less, till delivery; (3), the intense continued stretching of the uterus; (4), the continuous tense state of the membranes presenting; (5), the existence of all the symptoms of excessive bleeding without external manifestation. He described the causes of the separation as being due (*a*) to spasm of the uterus; (*b*) subjective violence, as coughing, stretching, violent exertion; (*c*) direct violence *ab utero*, and affirmed that the proper plan was *not* to rupture the membranes early.

Dr. GODSON had seen two cases of concealed accidental hæmorrhage, both fatal, and both unreported. In one, the membranes were ruptured, and the child was shot out forcibly on to the floor, and the hæmorrhage was so profuse that it resembled the spout from a cask when the tap was removed; in the other, the membranes were ruptured with no good result, and he should certainly try Dr. Brunton's plan on the first occasion.

Dr. HOPE, on the other hand, recommended early rupture of the membranes, and the free administration of ergot and stimulants, and the avoidance of any delay in the matter.

Dr. BRUNTON replied briefly.

*April 12th, 1875.*

Dr. ROUTH, President, in the Chair.

Dr. CRISP read a paper on the

#### NON-IDENTITY OF CROUP AND DIPHTHERIA,

in which he related cases of recent occurrence that appeared to him to show the non-identity of the two diseases. He believed that diphtheria, like "pleuropneumonia," and foot-and-mouth disease in the lower animals, was a malady of recent occurrence in this country,



and differed in a marked degree from genuine croup, which almost universally affected children under seven years of age, was a sthenic, non-contagious, local disease, far more fatal than diphtheria, taking into account the number affected ; and that it should not be classed with zymotic diseases.

On the other hand, diphtheria was a zymotic disease of a highly contagious nature, affecting in many instances not only the tonsils, fauces, and pharynx, but in some cases descending to the larynx, trachea, and smaller air-tubes, although, taking a large number of cases, the croupal complications were comparatively rare. That, taking age, sex, locality, sanitary conditions, symptoms, pathological appearances, and various complications enumerated, seen in diphtheria, which are not present in croup, he was surprised that the diseases could have been considered identical. Instances were given from the Registrar-General's Reports to substantiate the correctness of the author's view.

Dr. SEMPLE apologised for speaking early in the debate, but inasmuch as his opinions on croup and diphtheria had sometimes been misunderstood, he wished to explain distinctly what they really were. It had been supposed that he had regarded croup and diphtheria as synonymous words, but nothing was further from his meaning. In order to set forth clearly the terms of the problem, it was necessary to refer to the mode in which the word "croup" was introduced into medicine. This word, or "roup," is a vulgar colloquial Scotch monosyllable, implying any hoarseness or rough breathing, and it was adopted towards the end of the last century to indicate a disease observed in Scotland by Dr. Francis Home, and in which that physician distinctly saw a false membrane in the larynx and trachea of the patients after death. The word having been so used was adopted in France, to imply the disease of the trachea in which there is a false membrane, but by a certain looseness of application, croup was soon indiscriminately used to specify any disease of the larynx and windpipe, whether there was a false membrane or not. Dr. Semple drew upon the black board the names of the three diseases which thus became confounded under "croup" viz. 1. Membranous croup ; 2. Non-membranous croup ; and 3. Spasmodic croup. At the beginning of the present century, a grand child of the Empress Josephine died of what was called "croup," and the Emperor offered a prize for the best essay on that disease, with especial reference to the best method of cure. The competitors for this prize were of

various nations, and included Double, Valentin, Vieusseux, Jurine, and Albers, of Bremen, and to the last two the prize was jointly awarded. Dr. Semple invited any of the members to read those essays, and they would find that the authors had all of them confounded under the term "croup" the three diseases the names of which he had drawn on the black board. Albers, of Bremen, who obtained the prize for his essay, which was entitled "De Tracheitide Infantum, vulgo croup vocatâ," evidently confounded the mild and the serious diseases together, for he tells us that out of a great number of cases he had lost only one, and that one died only because he (Albers) was not called in sufficiently early. Albers was no doubt perfectly veracious, and thought that he cured the patients; but could any one in the present day believe that so serious a disease as that in question could be uniformly cured by bleeding and calomel? Soon after these essays were published, an epidemic broke out at Tours, in France, and, as is well known, attracted the attention and engrossed the care of Bretonneau, who, in accordance with the French nomenclature then prevailing, called it "croup," because he thought (and thought rightly) that it was the same disease as that described by Francis Home, who had given it that name. Bretonneau pursued his investigations diligently and carefully, in combination with his then pupils, Velpeau and Trousseau, and asserted nothing which he could not prove. He found in all his post-mortem examinations that there was a false membrane in the larynx and trachea, and he soon discovered that the word "croup," as used by his predecessors and contemporains, was unmeaning and vague, and he therefore proposed for the new disease (for it was then new to him) the word *Diphthérite* or *Diphthérie* from the false membrane (*διφθέρα*) which he invariably found. He at the same time excluded those ordinary inflammatory diseases of the trachea in which there was no false membrane. Having satisfied himself, then, that an epidemic really existed in his neighbourhood (from 1818 to 1826), characterised by the presence of a false membrane in various parts of the body, and, when invading the larynx and trachea, carrying off a multitude of victims, he next began to investigate the question whether the disease was really a new one, or whether it had existed, though under different names, at former periods, and whether it had been described by medical writers. By a combined process of reasoning and research he convinced himself, both that it had previously existed and that it had been described; and Dr. Semple would refer



the meeting to the original works of the Spanish physicians, Herrera, Fontecha, and Villa Real, who distinctly describe the false membrane in the windpipe in the epidemics occurring in Spain at the end of the sixteenth century; to the monographs of Ghisi, of Cremona; and of Nola, Sgambatus and Carnevale, of Naples; and of Cortesius, in Sicily, who all describe the same pathological appearance in the Italian epidemics at the beginning or middle of the seventeenth century; to the treatise of Marteau de Grandvilliers, who describes an epidemic (with false membrane) in Picardy, in France, in the middle of the eighteenth century; and to other monographs, all distinctly indicating the false membrane, such as that of Wilcke, who describes an epidemic in Sweden; of Bard, who describes one in New York, where Washington died of the disease; of Starr, in Cornwall, and several others. It is true that these epidemics occurred only at capricious and sometimes distant intervals of time; but Dr. Semple asked, was not the same fact true of other epidemics, as, for instance, even those of small pox and scarlatina, but more especially of such diseases as relapsing fever, which sometimes dissappeared altogether for many years? Again, is it not equally true that epidemic diseases often assume a sporadic type, as even in such cases as typhus and typhoid fevers and scarlatina? The ancient epidemics now referred to were therefore exactly the same in their nature as the epidemic of Tours; but Bretonneau distinctly separated them all from the ordinary inflammatory affections of the throat, which occur usually in cold weather. So far then from croup and diphtheria being synonymous, the former word ought to be rejected entirely, as including (in medical writings) three different diseases, viz. 1. Laryngo-tracheal diphtheria, or what was called membranous croup; 2. Laryngitis stridulosa, or what was called non-membranous croup; and 3. Laryngismus stridulus, or spasmodic croup. Laryngo-tracheal diphtheria differs from laryngitis stridulosa in the following respects: The first is epidemic, and independent of locality and seasons; the second is not epidemic; and is influenced by weather, season, and locality. The first is contagious though not highly so; the second is not contagious at all. The first is constitutional, as is proved by the frequent complication or supervention of albuminuria and paralysis; the second presents no such complications or sequelæ. Unfortunately, these two diseases (and laryngismus stridulus in addition) were all confounded together by the French writers (whose names are given above) *before* Bretonneau's researches, and the



mistake was transferred into English medical literature in Dr. Copland's valuable dictionary. But Bretonneau clearly distinguished them from each other, and the distinction has been made still more clear by the writings of his successors Bouchut, Guersant, Trousseau, Valleix, Rilliet and Barthez, and Daviot. With regard to the cases brought forward by Dr. Edwards Crisp, Dr. Semple had not a word to say in objection to them: they were recorded with the accuracy which might have been expected from a gentleman of Dr. Crisp's great acquirements as a pathologist and a physician. His cases of diphtheria were undoubtedly instances of that disease, for Dr. Crisp saw the false membrane in each; but his two cases of croup were what Dr. Semple would call instances of laryngitis stridulosa, for Dr. Crisp saw no false membrane in either of them, and it was illogical to assume, as Dr. Crisp appeared to have done, that the false membrane was swallowed or that it had otherwise disappeared.

Mr. LENNOX BROWN said, all sore-throat cases were called diphtheria, and instances of slight tonsillitis with whitish deposit on one tonsil were set down as cases of this terrible disease. Had Dr. Crisp used the laryngoscope for diagnosis?

Mr. HENRY SMITH came to the conclusion, years ago, that croup and diphtheria were quite distinct diseases; that croup was a local malady, occasionally relieved by operation; and that diphtheria was a blood disease, giving rise to membranous exudations on various surfaces. He was quite astonished at the opinions held on the subject by various eminent physicians.

Dr. DAY confirmed Dr. Crisp's views. The history of inflammatory croup differed entirely from that of diphtheria; the former was accompanied with acute inflammatory symptoms, a flushed countenance, and a bounding pulse. A membrane was coughed up and recovery quickly followed, and the treatment he would advise was a vapour bath. On the other hand, diphtheria was a general blood disease, accompanied by symptoms of great depression, by albuminuria, by various exudations from the mucous surfaces, and the treatment was quite different from that of croup.

Drs. BRUNTON and DRYSDALE also spoke.

Dr. CRISP, in reply, stated that it was difficult to use the laryngoscope in a child under two years of age. He maintained that these cases of croup were genuine.

Dr. SYMES THOMPSON read a communication from Staff Surgeon L. H. J. HAYNES, R.N., on an

## EPIDEMIC OF ENTERIC FEVER OCCURRING ON BOARD H.M.S. "DORIS," IN THE WEST INDIES, IN 1873.

The author, after enumerating the usual symptoms of the diseases, gives an account of the epidemic in which twenty-nine men were attacked and two died, the cause of fever being traced to the bad water supplied to the ship, which contained a quantity of organic matter, and no less than three different kinds of animalculæ. The post-mortem appearances were enumerated and an account given of an elaborate examination of the ship's air.

Some remarks were made by Dr. FAYRER and Dr. WILLIAMS, and the meeting adjourned.

*April 19th, 1875.*

Dr. ROUTH, President, in the Chair.

Mr. G. H. PEDLER exhibited

### THE PNEUMATOGRAPH,

which is, as its name implies, an instrument for the graphic representation of the process of respiration.

It consists of a breathing tube, from which depends a bent tube which is partly filled with fluid (generally water); on the level of the fluid, in the distant arm of the bent tube, is a pith base (coated with paraffin to prevent water logging), and into this pith base is fixed an upright light, but firm, standard, say of whalebone; at the top of this standard there is fixed at right angles a thin piece of metal which is sharpened at the far end and bent on itself; this performs the duty of a pen. The clockwork and tramway are fixed at the top of the far end of the bent tube. As the inspiration and expiration proceed through the breathing tube (the nostrils being closed), the level of fluid in the near arm of the bent tube fluctuates with every change of tension in the breathing tube, and consequently the level of fluid at the distant end is likewise affected, and the pen marks on the slide of blackened glass as it passes the exact representation of every modification in both the inspiration and the expiration.

At the orifice of the breathing tube is a square opening, with a sliding square sheath, so that the area of breathing orifice can (and it should always) be noted on the glass slide.

Dr. WILLIAMS preferred applying any apparatus of this sort to the chest wall rather than the mouth; in the case of a nervous patient it would be very difficult to arrive at any conclusion, as the record would vary so much.

Dr. DRYSDALE feared that phthisical patients are difficult to make breathe sufficiently well for the instrument to be available.

Dr. B. W. RICHARDSON then gave a further report in the treatment, *in extremis*, of cases of

#### FIBRINOUS SEPARATION WITHIN THE HEART AND THE VESSELS OF THE CIRCULATION.

The paper read by the author was in continuation of one on the same subject read before the Society in the session of 1872. He had related the details of four more cases in which he had administered ammonia in large doses for the purpose of causing resolution of pectous fibrine in the right side of the heart or in the great vessels. The first case was that of a lady whom the author had attended in consultation with Mr. Andrew, of Queen's Crescent, Haverstock Hill, and who, twelve days after confinement, was seized suddenly, while being raised in bed, with all the symptoms of obstruction on the right side of the heart. She was treated with five-minim doses of liquid ammonia administered in iced water or iced milk every half hour. This treatment was continued for four days, at the end of which time resolution of the coagulum was indicated by the removal of the dyspnoea and the restoration of the natural condition of the heart. There was occurrence, on the resolution of the coagulum, of secondary symptoms of a pyæmic kind, from which, however, under the continued influence of the ammonia, perfect recovery followed. The second case referred to was similar in character, and was still under treatment, with every prospect of recovery, the secondary symptoms having become established, and being comparatively slight. The third case was one in which the symptoms followed the exposure to septic matter, and in which the coagulation of the fibrine occurred primarily in the whole length of the left femoral vein. The patient, in this instance, was treated with aromatic spirit of ammonia in doses of one fluid drachm every hour in milk or iced water. Com-



plete resolution of the coagulum occurred, with severe secondary symptoms, and with formation of abscess in the lung, but with ultimate perfect recovery under the continued action of the alkali. The amount of the aromatic ammonia solution administered in the course of this case was three pints and fifteen ounces, yet no bad effect whatever attended the employment of the remedy. The fourth case was one in which Mr. Spencer Wells had performed ovariectomy. The obstruction in this instance was first developed in the heart, and the ammonia treatment was instituted. In a few hours symptoms of cerebral obstruction were developed, which Dr. Richardson attributed to a separation of fibrin in the pectous state within the cerebral sinuses. This patient died from cerebral effusion, and the post-mortem examination proved that the diagnosis was correct, the lateral sinuses being obstructed by two long cylinders of white fibrinous matter. The blood on the right side of the heart in this patient was fluid and ammoniacal, with some small residue of undissolved coagulum adhered to the muscoli pectinati of the right auricle.

After the minute narration of these examples of disease, Dr. Richardson passed to the practical lessons suggested by them. He described the diagnosis of obstruction on the right side of the heart, considering (*a*) the characteristic dyspnoea with open-air passages; (*b*) the fulness of the veins of the neck; (*c*) the feeble pulse, with the tumultuous, and, it may be, forcible, stroke of the heart; (*d*) the diminished quality of the first sound of the heart; (*e*) the differentiation of the action of the tricuspid and mitral valves in respect to the first sound; a suppressed sound, not a murmur, being defined as the true physical indication of the presence of the coagulum.

In connection with the question of diagnosis, the author showed that a series of hysterical symptoms might in some persons so closely imitate the symptoms of obstruction it was difficult at first to distinguish between them and the true affection. The spurious symptoms of the disease were recognisable from the actual by the physical signs to a certain extent, but that which proved them most certainly to be spurious or imitative was the rapidity with which under any or no treatment they passed away.

The subject of treatment was next commented on, together with the persistent administration of the ammonia until the whole volume of the blood is under the influence of the alkali; absolute

rest of the body in the horizontal position, and in one position, was urgently enforced. The diet insisted on was milk chiefly, with avoidance of solid food and of alcoholic stimulants in every form. The employment of sedatives, of opium especially, was forbidden. The heart, in a word, must neither be stimulated nor depressed in its action, but simply supported until the obstruction within it is resolved.

The *modus operandi* of the ammonia treatment was entered into at length. The remedy was not given, the author said, as a stimulant, neither was it given for the purpose of reducing febrile heat, though it might indirectly assist in this latter intention; but it was given to act as a solvent on the blood, and to prevent putrefactive changes.

In illustration of its action in these particulars, a specimen of blood was shown which was still fresh and still fluid, although it had been kept from the 10th of last October, over six months. It had been held in this preserved and fluid state simply by the presence of ammonia. In another illustration, the value of ammonia over fixed alkalies was also made clear. A brief summary of facts and rules brought the paper to a close, with the observation that if he (the author) had suggested a plan of treatment which in one case out of four should save the sufferer from impending death, he should feel the happy consciousness of having essayed a good work. But the labour must not rest here, for the same direction of treatment applied, under a clearer knowledge, at some earlier diagnosable point in the cause of the many diseases which terminate by and from pectous change of blood, may ultimately destroy the triumph of curing *in extremis* by preventing the catastrophe which that term so expressively defines.

Dr. SEMPLE begged to express his sense of the great importance of the subject brought forward by Dr. Richardson, and of the admirable way in which he had treated it. In further illustration and amplification of the questions concerning fibrinous clots in the heart, Dr. Semple alluded to the views entertained of their nature in former years, when they were described as *polypi*, and regarded as diseases. But they were found so often in the post-mortem examinations, that they were subsequently looked upon as being caused by some ordinary ante-mortem or post-mortem change, and not as possessing much pathological significance. Bouillaud, in his well-known work, the '*Traité Clinique des Maladies du Cœur*,'



laid much stress upon them as resulting from endocarditis, which disease he was the first to describe. It was quite evident, however, from reading Bouillaud's work, that he had assembled together in his descriptions not only instances of endocarditis properly so called, but also chronic diseases of the valves, and hypertrophy with dilatation, while many of his cases were avowedly due to phlebitis and pyæmia. Dr. Richardson had developed, with great ability, many years since, his views as to the formation of fibrinous clots in the heart during life and their great danger, and had shown how they might be detected and removed. Since these views were promulgated many new discoveries and researches had been made in cardiac pathology, and not only was that most fatal malady, *fatty degeneration of the heart*, brought into prominent notice, but the whole subject of *embolism*, due to the disintegration of fibrinous masses from the cardiac valves, had been developed. A German writer, Cohn, had devoted a whole book to this theme, entitled 'Die Embolischen Krankheiten,' in which Dr. Richardson's researches had received, as they deserved, most honorable mention. Dr. Semple, if he understood Dr. Richardson's cases correctly, thought that some of them were instances of affections in some way connected with pyæmia or blood poisoning. But in a therapeutic point of view, Dr. Richardson's conclusions were most valuable, and if it should be generally established that ammonia was a solvent of the clots, inestimable benefits would be conferred on science and humanity.

Dr. DALDY wished to know if ammonia was really a solvent of fibrinous concretions of the blood; he thought Dr. Richardson had not given proper consideration to the part which the vessels containing the blood play. Coagula formed in veins in various parts of the body as a result, not of the state of the blood, but of the state of the vessels; the right auricle, which was nothing more than a large vein, was structurally adapted to expand when formation of coagula took place in it. The heart is abundantly supplied with nervous ganglia. Have these no part in the phenomenon, or is the blood the only actor? Dr. Richardson's cases were all instances where fibrine existed in excess, and therefore favorable for treatment; but he (Dr. Dalby) has seen cases in which after death blood was still fluid; and he still doubted if Dr. Richardson did not assign too much to the blood and too little to the other organs.

The PRESIDENT stated that he had seen three cases of this



affection. All had been treated according to Dr. Richardson's directions; two recovered perfectly; the third died, but afforded positive evidence of the excellence of the treatment.

Dr. RICHARDSON, in reply, stated that coagulation of blood had taken place in one case from septic poison, causing a lump in the femoral vein. The same occurred in croup, scarlet fever, erysipelas, and could be seen in superficial veins. In his case the right auricle had evidently been the seat of the clot; he did not know, if the clot had extended through the ventricle into the pulmonary valves, whether the ammonia treatment would have succeeded; the clot was evidently softened by it and dispersed. Ammonia might be given to a very large extent, and one young lady had taken 3 pints 15 oz. of spirit ammon. aromat. before recovery without any bad symptom.



*April 26th, 1875.*

Dr. ROUTH, President, in the Chair.

Mr. WILLIAM ADAMS read a paper

ON THE TREATMENT OF BROKEN-NOSE BY FORCIBLE  
STRAIGHTENING, AND MECHANICAL RETENTIVE  
APPARATUS.

The author observed that all cases of so-called broken-nose may be divided into two classes, viz.

1st. Those in which the injury is limited to the anterior, or cartilaginous portion of the nose, and consists essentially of depression, with lateral bending of the cartilaginous septum; a partial displacement of this septum from its attachment to the vomer also occurring in some cases.

And 2ndly. Those in which the nasal bones are fractured, with more or less depression and lateral displacement, in addition to depression and lateral bending of the cartilaginous septum.

The cases which had fallen under the author's observation had generally been at periods varying from one to six months after

the accident; but in one case the accident had occurred six years previously.

In all these cases the principle of treatment adopted was, the patient being under chloroform, to straighten the bent cartilaginous septum with a pair of strong forceps, with flat parallel blades; and when the nasal bones are depressed, to raise these also, by carrying the blades of the forceps directly upwards, lateral pressure being made externally by the thumb, at the same time that the bones are raised from within.

A retentive apparatus is then employed, consisting of a steel screw-compressor, applied so as to support the septum. This can be worn for two or three days and nights without removal, then ivory plugs used to support the septum and nostrils.

In some cases where the nasal bones have been fractured, a retentive apparatus may be employed externally by means of a movable pad, attached to a steel band passing round the head. In recent cases it is seldom necessary to employ any retentive apparatus, the nasal bones and the cartilaginous septum, not being subjected to any muscular influences tending to cause displacement, retain their improved position and relations.

If the swelling and ecchymosis should be too great to allow of this treatment being adopted soon after the accident, it would be advisable to wait a week or ten days, and then resort to the method of forcible straightening described.

Four cases illustrating this method of treatment were related, and the forceps and retentive apparatus exhibited to the Society.

A short discussion followed.

Mr. HENRY SMITH read a paper on the

#### RESULTS AFFORDED BY FOUR HUNDRED CASES OF HÆMORRHOIDS AND PROLAPSUS OPERATED ON BY THE CLAMP AND CAUTERY.

He commenced his paper by a short description of the operation, which essentially differed from that of the ligature, inasmuch as by the process adopted this tumour or tumours were bodily and thoroughly removed at once by the clamp and scissors, and the hæmorrhage was prevented or arrested by the heated iron; whereas, in that by the ligature, the operation could not be said to be completed at the time, as some days must of necessity elapse before the

separation of the ligatures. In the last paper read by him before the Society, two years since, he had given the results of 300 cases, in which series he had met with three deaths, which were at that time fully detailed, and when his patients were so reduced in health that the fatal event could not well be placed to the account of the particular kind of operation performed. In the last series, however, he had met with one fatal case, when doubtless the death was due to the too vigorous use of the cautery; it was a very severe case of hæmorrhoids and prolapsus of long standing in an old gentleman, where this operation was a very severe one, and where the bleeding was so great that, in order to arrest it, he had to use the clamp and cautery very freely indeed, and the patient died in a few days with symptoms of peritonitis. He believed that the peritoneum must have been either directly or indirectly affected. In similar cases he should hope to avoid such a result by only removing the superficial portions of mucous membrane and dealing very freely with the external portion of the growth. He had met with no other fatal cases in the last series.

Of pyæmia after this operation he had not met with one case, although one patient underwent a severe operation. Some of the symptoms of this disease were present, and caused him anxiety, but recovery took place. There had been two instances only of erysipelas after this operation, and these both occurred in the last series of cases.

Hæmorrhage either immediately after the operation, or some days after, was really about the only thing to be feared, and his experience led him to believe that, if it did occur, it was from the fault of the surgeon, who either used imperfect instruments, or did not apply the cautery sufficiently. He himself had never met with a case where the bleeding was so severe as to demand plugging of the rectum. He had, however, met with six cases in the last series, where bleeding demanding active measures had occurred. In two of these cases the bleeding was immediately after the operation, and was due to his own carelessness in allowing a divided vessel to retract up into the bowel. No harm, however, came of this. In four cases the bleeding was secondary after the first action of the bowels, but was mainly the production of blood which had escaped into the bowel at the time of the operation; in two of these instances there had been free removal of muco-cutaneous growths without the application of the cautery, and he believed the bleeding resulted from these wounds. It was his firm belief, that if the surgeon were only



sufficiently careful to use proper instruments, and apply the cautery thoroughly, and not too hot, neither primary nor secondary bleeding would occur. In three cases some contraction had taken place after the operation, but this was in consequence of his having removed skin too freely; this, however, may be effectually avoided by the use of bougies after the operation. In one case fistula had occurred, but as he had not the after-treatment of the case, he did not hold himself responsible for this mistake.

Mr. HEATH STRANGE exhibited a modification of Mr. Smith's clamp, used by Mr. Gowlland, which could be used with one hand, while the other could hold the buttocks apart.

Mr. GOWLLAND said he had modified his views as to the clamp, and regarded it as excellent in certain cases of internal hæmorrhoids; there was no great gain as regards the lessening of the pain, and hæmorrhage occurred even at the operation; often troublesome ulceration occurred, causing pain during the passage of motions. If stricture arose, he thought it would be from contraction of the ulcer of the bowel, and not from contracted orifice. He did not find recovery quicker after the clamp than after the ligature.

Mr. THOMAS BRYANT had commenced by using the ligature, but following the author's recommendation he tried cautery, and found better results. For the last seven years he had used the galvanic cautery, as the heat was more persistent and ready at hand. Cases certainly did recover more rapidly than with the ligature; there was no hæmorrhage, no ulceration, no large retained clot, or subsequent stricture with the cautery.

Mr. ROYES BELL dwelt strongly on the advantage of the clamp and cautery, adducing some interesting cases in support of Mr. Smith's views.

Mr. HENRY SMITH, in reply, said that the operation originated in Ireland, and he was glad to find that it had gained ground under his advocacy. He remarked that pyæmia might occur to any one, but the sealing of vessels by heat is the better method of preventing that result: he had never met with stricture of the bowel from this cause.

Dr. SEDGWICK then read for Dr. METCALF, of Geneva, a case of numerous and severe injuries resulting from a fall.

Dr. RICHARDSON reports to the Society, through the President,

that the patient under the ammonia treatment for fibrinous obstruction on the right side of the heart, referred to by him (Dr. Richardson) at last meeting, may now be considered as convalescent.

On visiting her to-day, April 26th, Dr. Richardson finds her able to sit up. The sounds of her heart are clear and natural; her breathing is natural, and the secondary pneumonic complication has passed away. With the exception of anæmia, in this instance slight, but which seems always to follow for a short time the large administration of ammonia, no symptom calculated to give anxiety remains.

From the readiness with which Dr. Read, who attended the patient in her confinement, diagnosed her condition when the alarming symptoms first manifested themselves, and from the promptness with which he placed her under the influence of ammonia, the resolution of the obstruction was greatly expedited, and the success of the treatment was facilitated.

The amount of ammonia administered was one fluid ounce and a half in five-minim doses, at intervals of half an hour.

A letter was read from the Rev. THOMAS POWELL, F.L.S., missionary at Samoa, in the South Pacific, calling attention to the excellent effects he had experienced resulting from the application of a strong decoction of *Rhisopfera* bark, in cases of venous ulcer, and a specimen of the same was enclosed and shown to the Society.

*May 3rd, 1875.*

Dr. ROUTH, President, in the Chair.

The ANNUAL ORATION\* was delivered by Dr. GEORGE BUCHANAN, to a large audience. His subject was, "On some important points relative to Modern Hospitals." At the conclusion, a vote of thanks was proposed by Professor Erasmus Wilson, seconded by Dr. Symes Thompson, and carried unanimously.

The *Conversazione*, which followed, was well attended, and many interesting objects were brought before the notice of the Fellows.

\* A copy of this Oration has been forwarded to each of the Fellows.







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